(65)

No. 95-1858-CFX Title: Dennis C. Vacco, Attorney General of New York, et al., Petitioners
v.
Timothy E. Quill, et al.

Docketed:
May 16, 1996 Court: United States Court of Appeals for the Second Circuit

See also:
96-110

Entry	Date	Proceedings and Orders
	May 16 1996	Petition for writ of certiorari filed. (Response due June 15, 1996)
	Jun 14 1996	Brief amici curiae of California, et al. filed.
	Jun 14 1996	Motion of Agudath Israel of America for leave to file a brief as amicus curiae filed.
	Jun 14 1996	Motion of Carl Anderson, Commissioner, et al. for leave to file a brief as amici curiae filed.
	Jun 14 1996	Motion of United States Catholic Conference, et al. for leave to file a brief as amici curiae filed.
	Jun 17 1996	Brief of respondents Timothy Quill, et al. in opposition filed.
	Jun 17 1996	Motion of Catholic Medical Association for leave to file a brief as amicus curiae filed.
	Jun 17 1996	LODGING consisting of ten copies of the U.S. Commission on Civil Rights publication," Medical Discrimination Against Children with Disabilities" submitted by counsel for amici Carl Anderson, et al.
	Jul 1 1996	Opposition of respondents to motion of Agudath Israel of America and all amici for leave to file a brief as amicus curiae filed.
	Jul 2 1996	DISTRIBUTED. September 30, 1996
	Jul 10 1996	Reply brief of petitioners Vacco, NY Atty. Gen., et al. filed.
	Sep 9 1996	Supplemental brief of respondents Timothy Quill, et al. filed.
	Oct 1 1996	Motion of Agudath Israel of America for leave to file a brief as amicus curiae GRANTED.
	Oct 1 1996	Motion of Carl Anderson, Commissioner, et al. for leave to file a brief as amici curiae GRANTED.
	Oct 1 1996	Motion of United States Catholic Conference, et al. for leave to file a brief as amici curiae GRANTED.
	Oct 1 1996	Motion of Catholic Medical Association for leave to file a brief as amicus curiae GRANTED.
	Oct 1 1996	Petition GRANTED. The brief of petitioners is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, November 12, 1996. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, December 10, 1996. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, December 27, 1996. Rule 29.2 does not apply. The case is set for oral argument in tandem with No. 96-110, Washington v. Glucksberg.

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Entry	Date	Proceedings and Orders
		SET FOR ARGUMENT January 8, 1997.
		**********
	Nov 7 1996	Brief amici curiae of Gary Lee, et al. filed. VIDED.
	Nov 7 1996	Brief amici curiae of Members of the New York and Washington State Legislatures filed. VIDED.
	Nov 7 1996	LODGING consisting of eleven copies of Vol 12, No.2 of Issues in Law & Medicine submittee by counsel for the amici, Gary Lee, et al.
	Nov 8 1996	Brief amici curiae of California, et al. filed.
	Nov 12 1996	Joint appendix filed.
	Nov 12 1996	Brief of petitioners Vacco and Pataki filed.
	Nov 12 1996	Brief amicus curiae of American Life League, Inc. filed.
	Nov 12 1996	Brief amici curiae of United States Catholic Conference, et al. filed.
	Nov 12 1996	Brief amicus curiae of Choice in Dying, Inc. filed.
	Nov 12 1996	Brief amici curiae of Not Dead Yet, et al. (TO BE REPRINTED) filed.
	Nov 12 1996	Brief amici curiae of Jerome DeCosse, et al. filed.
	Nov 12 1996	Brief amicus curiae of Clarendon Foundation filed.
	Nov 12 1996	Brief amici curiae of American Medical Association, et al. filed.
	Nov 12 1996	Brief amicus curiae of Medical Society of New Jersey filed.
	Nov 12 1996	Brief amicus curiae of United States filed.
	Nov 12 1996	Brief amicus curiae of National Hospice Organization filed. VIDED.
	Nov 12 1996	LODGING consisting of one paperbound book entitled Dying Well, submitted by counsel for amicus, Natl. Hospice Organization
	Nov 12 1996	Brief amicus curiae of American Geriatrics Society filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Catholic Health Association filed. VIDED.
	Nov 12 1996	Brief amici curiae of Natl. Catholic Office for Persons With Disabilities, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Richard Thompson, Oakland County Prosecuting Attorney filed. VIDED.
	Nov 12 1996	Brief amici curiae of Senator Orrin Hatch, et al. filed. VIDED.
	Nov 12 1996	LODGING consisting of ten copies of Serial 78, Hearing before the Subcommittee on the Constitution, entitled, Assisted Suicide in the United States, submitted by counsel for Orrin Hatch, et al.
	Nov 12 1996	Brief amicus curiae of International Anti-Euthanasia Task Force filed. VIDED.
	Nov 12 1996	Brief amicus curiae of American Hospital Association filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Bioethics Professors filed. VIDED.
	Nov 12 1996	Brief amici curiae of National Association of Prolife Nurses, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Family Research Council filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Project on Death in America, Open Society Institute filed. VIDED.

No. 95-1858-CFX

Entry	Date	Proceedings and Orders
	Nov 12 1996	Brief amicus curiae of Agudath Israel of America filed. VIDED.
	Nov 12 1996	Brief amici curiae of American Assn. of Homes and Services for the Aging, et al. filed. VIDED.
	Nov 12 1996	Brief amici curiae of Institute for Public Affairs of UOJCA, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Catholic Medical Association filed. VIDED.
	Nov 12 1996	Brief amicus curiae of American Center for Law & Justice filed. VIDED.
	Nov 12 1996	Brief amici curiae of Natl. Legal Ctr. for Medically Dependent & Disabled, et al. filed. VIDED.
	Nov 12 1996	Brief amici curiae of Christian Legal Society, et al. filed. VIDED.
	Nov 12 1996	Brief amicus curiae of Evangelical Lutheran Church in America filed. VIDED.
	Nov 12 1996	Brief amicus curiae of American College of Legal Medicine filed. VIDED.
	Nov 15 1996	CIRCULATED.
	Dec 9 1996	Brief amici curiae of National Women's Health Network, et al. filed. VIDED.
	Dec 9 1996	Motion of Wayne County, Michigan for leave to file a brief as amicus curiae filed.
	Dec 9 1996	Motion of Surviving Family members in Support of Physician - Assisted for leave to file a brief as amicus curiae filed.
	Dec 10 1996	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Dec 10 1996	Brief amici curiae of Gay Men's Health Crisis, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Julian Whitaker filed. VIDED.
	Dec 10 1996	Brief amici curiae of Washington State Psychological Association, et al. filed. VIDED.
	Dec 10 1996	Brief amici curiae of Ronald Dworkin, et al. filed. VIDED.
	Dec 10 1996	Brief of respondents Timothy E. Quill, Samuel Klagsbrun, and Howard A. Grossman filed.
	Dec 10 1996	Brief amici curiae of American Medical Student Association, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of State Legislators filed.
	Dec 10 1996	Brief amici curiae of American Civil Liberties Union, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Coalition of Hospice Professionals filed.
	Dec 10 1996	Brief amicus curiae of Bioethicists filed. VIDED.
	Dec 10 1996	Brief amici curiae of Americans for Death With Dignity, et al. filed. VIDED.
	Dec 10 1996	Brief amicus curiae of Law Professors filed. VIDED.
	Dec 10 1996	Brief amici curiae of 36 Religious Organizations, Leaders and Scholars filed. VIDED.

No. 95-1858-CFX

Entry	Date	Proceedings and Orders
	Dec 10 1996	LODGING of one copy of "Death With Dignity FAQS" submitted by counsel for amici Washington State Psychological Assn., et al.
	Dec 12 1996	Record filed.
	Dec 16 1996	Motion of the Acting Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Dec 16 1996	Motion of Wayne County, Michigan for leave to file a brief as amicus curiae GRANTED.
	Dec 26 1996	Reply brief of petitioners Dennis C. Vacco, Attorney General, et al. filed.
	Jan 8 1997	ARGUED.
	Jan 9 1997	Record filed.

No. __-_____

Supreme Court, U.S.
FILED
95 1858 MAY 16 1996
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM 1995

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Should this Court grant certiorari to settle the question of whether, under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, a state retains a legitimate interest in prohibiting physician assisted suicide while allowing terminally ill, mentally competent patients to refuse artificial life support?

2. Should this Court grant certiorari to resolve a conflict between the United States Court of Appeals for the Second Circuit and a state court of last resort on the issue of whether the Equal Protection Clause prohibits the states from banning physician assisted suicide?

LIST OF PARTIES

The following parties were appellants in the court below: Timothy E. Quill, M.D.; Samuel C. Klagsbrun, M.D.; and Howard A. Grossman, M.D. All are respondents here. The appellees in the court below included Dennis C. Vacco, Attorney General of the State of New York; George E. Pataki, Governor of the State of New York; and Robert M. Morgenthau, District Attorney of New York County. All are petitioners here.

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED	i
LIST OF PARTIES	ii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	2
JURISDICTION	2
CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED	2
STATEMENT OF THE CASE	3
REASONS FOR GRANTING THE PETITION	4
I – THE SECOND CIRCUIT'S EQUAL PROTECTION ANALYSIS SWEEPS ASIDE HISTORICAL AND RATIONALLY-BASED STATE LIMITATIONS ON THE RIGHT OF SELF-DETERMINATION AND LEAVES THE LAW IN THIS AREA IN SUBSTANTIAL CONFUSION	5
a. The Historical Framework of Penal Law Sections 125.15(3) and 120.30	6
b. Evolution of New York's Law Through the Work of the New York State Task Force on Life and the Law	7

PAGE

c. Legitimate State Purposes Underlying New York's Ban on Assisted Suicide 9

d. A "Confused Enterprise" of Legislating 12

II – THE SECOND CIRCUIT HAS DECIDED AN IMPORTANT FEDERAL QUESTION IN A MANNER THAT CONFLICTS WITH A DECISION OF THE HIGHEST STATE COURT OF MICHIGAN AND WHICH IS AT SIGNIFICANT ODDS WITH THE REASONING OF THE NINTH CIRCUIT ON THE SAME ISSUE 14

CONCLUSION 17

APPENDIX

Decision of the United States Court of Appeals for the Second Circuit dated April 2, 1996 ..... 1a

Opinion and Order of the United States District Court for the Southern District of New York dated December 15, 1994 ..... 63a

TABLE OF AUTHORITIES

Cases PAGE

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) (en banc) ..... *passim*

Compassion in Dying v. State of Washington, 49 F.3d 585 (9th Cir. 1995) 16

Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 110 S. Ct. 2841 (1990) 10, 12, 13

Eichner v. Dillon, 73 A.D.2d 431, 426 N.Y.S.2d 517 (2d Dep't 1980) 10

In re Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976) 9

Matter of Storar, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981) 11

People v. Duffy, 79 N.Y.2d 611, 595 N.E.2d 814 (1992) 7

People v. Kevorkian, No. 93-11482, 1993 WL 603212 (Mich. Cir. Ct. Dec. 13, 1993) 15

People v. Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1795 (1995) ..... *passim*

Planned Parenthood v. Casey, 505 U.S. 833, 112 S. Ct. 2791 (1992) 10

Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) ..... *passim*

San Antonio School Dist. v. Rodriquez, 411 U.S. 1, 93 S. Ct. 1278 (1972) 6

PAGE

Statutes and Rules

U.S. Const. Amend. XIV ..... *passim*

28 U.S.C. § 1254 2

42 U.S.C. § 1983 3

N.Y. Penal Law § 125.15(3) (McKinney's 1987) ..... *passim*

N.Y. Penal Law § 120.30 (McKinney's 1987) ..... *passim*

N.Y. Pub. Health Law § 2989(3) (McKinney's 1993) . 8

N.Y. Penal Code § 175 (1881) 6

1965 N.Y. Laws, c. 1030 7

9th Cir. R. 35-3..... 15

Other

"Doctors Offer Some Support to Kevorkian: Urge 10 Guidelines in Assisting Suicide," N.Y. Times, Dec. 5, 1995, at A21 12

J. Dougherty, LEGAL AND JUDICIAL HISTORY OF NEW YORK (1911) 6

J. Kevorkian, MEDICIDE: THE GOODNESS OF PLANNED DEATH (1991)..... 12

2 LaFave & Scott, SUBSTANTIVE CRIMINAL LAW (1986) 6

Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1 (1985)..... 6

PAGE

New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994) ..... *passim*

New York State Task Force on Life and the Law, *When Others Must Choose: Deciding for Patients Without Capacity* (March 1992)..... 7

New York State Task Force on Life and the Law, *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (July 1987) 7, 8

New York State Task Force on Life and the Law, *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* (April 1986) 7

STEDMAN'S MEDICAL DICTIONARY (4th Unabridged Lawyers' Ed.) (1976) 10

Temporary State Commission on Revision of the Penal Law and Criminal Code, *Proposed New York Penal Law to the Legislative Session of 1964* (1964) ... 7

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

No. __-____

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

Petitioners respectfully pray that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit entered on April 2, 1996. The court's decision held that physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to commit suicide during the final stages of a terminal illness.

OPINIONS BELOW

The decision of the United States Court of Appeals for the Second Circuit is reported at 80 F.3d 716 (2d Cir. 1996), and is reproduced in the appendix at 1a. The opinion and order of the district court is reported at 870 F. Supp. 78 (S.D.N.Y. 1994), and is reproduced in the appendix at 63a.

JURISDICTION

The decision of the United States Court of Appeals for the Second Circuit was rendered, and judgment entered, on April 2, 1996. This Court has jurisdiction to hear this petition pursuant to 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional and statutory provisions involved are the Due Process Clause and Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, and New York Penal Law Sections 125.15(3) and 120.30.

The Fourteenth Amendment, Section 1, to the United States Constitution provides in pertinent part:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Penal Law Section 125.15(3) is entitled "Manslaughter in the second degree" and provides in pertinent part:

> A person is guilty of manslaughter in the second degree when . . . (3) He intentionally causes or aids another person to commit suicide. Manslaughter in the second degree is a class C felony.

N.Y. Penal Law § 125.15(3) (McKinney's 1987).

Penal Law Section 120.30 is entitled "Promoting a suicide attempt" and provides:

> A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony.

N.Y. Penal Law § 120.30 (McKinney's 1987).

STATEMENT OF THE CASE

This case challenges the authority of a state to prohibit physicians from taking active steps to aid terminally ill patients in killing themselves. Respondents are three physicians who, together with three terminally ill patients,[1] brought suit pursuant to 42 U.S.C. § 1983 to contest the constitutional validity of New York Penal Law Sections 125.15(3) and 120.30, which make criminal the acts of causing or aiding another to commit suicide or to attempt suicide (JA 13-15).[2]

The respondent-physicians assert that New York's penal provisions violate their right under the Fourteenth Amendment to the United States Constitution to provide active assistance to terminally ill patients to enable them to commit suicide. In the courts below, they argued that the "Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives" (JA 15), that the right to

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[1] The plaintiff-patients died by the time the district court rendered its opinion, leaving only the physicians as appellants before the court of appeals. A physician-patient relationship existed between only one of the physicians and one of the plaintiff-patients.

[2] "JA" denotes the Joint Appendix submitted to the Second Circuit Court of Appeals.

assisted suicide is a fundamental right (JA 16), and that New York's laws are unconstitutional under the Due Process Clause (JA 16). They also asserted that because terminally ill people may request the withdrawal of life sustaining treatment, the prohibition of physician assisted suicide violates the rights, under the Equal Protection Clause, of those patients who are terminally ill but are not on artificial life support (JA 17).

In an opinion dated December 15, 1994 (63a), Chief Judge Griesa of the United States District Court for the Southern District of New York treated a cross-motion to dismiss as one for summary judgment (65a), and held on the merits that the criminalization of physician assisted suicide involved neither a denial of a fundamental liberty interest protected by the Fourteenth Amendment's Due Process Clause nor a denial of equal protection under that same Amendment (72a-77a).

The Second Circuit affirmed that portion of the district court's opinion that found no substantive due process right to assisted suicide. *Quill v. Vacco*, 80 F.3d 716, 724-25 (2d Cir. 1996) (19a). The Circuit Court concluded, however, that New York's penal provisions violate the Equal Protection Clause, finding that physician assisted suicide is analytically no different than the refusal of life-sustaining medical treatment, and that no rational basis exists to support New York's disparate treatment of the two. *Id.* at 727 (24a). The court thus invalidated New York Penal Law Sections 125.15(3) and 120.30 to the extent that those laws impose criminal penalties on physicians who prescribe lethal dosages of medication for their terminally ill, mentally competent patients to aid those patients in committing suicide. *Id.* at 731 (35a).

REASONS FOR GRANTING THE PETITION

This Court's review is sought because of the profound importance of the questions presented. The Second Circuit's decision creates an unprecedented substantive constitutional

right under the guise of guaranteeing equal protection of the laws, and in so doing, has "transform[ed] the right to decide about medical treatment into a far broader right to control the timing and manner of death." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, at ix (May 1994).

The interests at stake are critical. On an individual level, an erroneous decision by a physician in the course of assisting a suicide simply is not susceptible of correction. On a broader societal level, the outcome in this case will have enormous influence on whether assisted suicide becomes a standard part of our nation's medical practice, and on what will occur in hospitals, clinics and doctors' offices around the country.

Additionally, the decision below merits review because it decides an important federal question in a manner that directly conflicts with a decision by a state court of last resort. The Second Circuit's reasoning also is fundamentally at odds with that of the Ninth Circuit on the same issue.

I

THE SECOND CIRCUIT'S EQUAL PROTECTION ANALYSIS SWEEPS ASIDE HISTORICAL AND RATIONALLY-BASED STATE LIMITATIONS ON THE RIGHT OF SELF-DETERMINATION AND LEAVES THE LAW IN THIS AREA IN SUBSTANTIAL CONFUSION

Having declined to engage, under the Due Process Clause, in "the expansion of fundamental rights that are without support in the text of the Constitution," *Quill*, 80 F.3d at 724 (18a), the Second Circuit nonetheless granted constitutional protection to physician assisted suicide by employing an equal protection analysis of the challenged statutes. Predicated on a conclusion that assisted suicide is no different than the withdrawal of artificial life support, the Circuit Court declared that New York's prohibitions against physician

assisted suicide are not rationally related to a legitimate governmental interest and thus violate the Equal Protection Clause. In so holding, the court swept aside historical and rationally-based state limitations on the right of self-determination, and essentially "create[d] substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio School Dist. v. Rodriquez*, 411 U.S. 1, 33, 93 S. Ct. 1278, 1297 (1972).

a. The Historical Framework of Penal Law Sections 125.15(3) and 120.30

New York Penal Law Section 125.15(3) states that "a person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide." New York Penal Law Section 120.30 states that "a person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." The first is a class C felony, the second a class E felony.

The State's criminalization of, and thus essential prohibition against, aiding another in self-destruction dates from colonial times and was established in the common law. *See* J. Dougherty, LEGAL AND JUDICIAL HISTORY OF NEW YORK 16-17 (1911) (citing early cases recognizing the prohibition). While the act of suicide itself was not historically made criminal in most states, 2 LaFave & Scott, SUBSTANTIVE CRIMINAL LAW, § 78, at 246-251 (1986), by the time of the ratification of the Fourteenth Amendment, some twenty-one of the thirty-seven existing states, including New York, had statutes making the aiding of suicide a criminal act. Marzen, O'Dowd, Crone & Balch, *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 63, 76 (1985).

By 1881, New York had categorized as first degree manslaughter the act of advising, encouraging, abetting or assisting another person to commit suicide. N.Y. Penal Code § 175 (1881). The State's current statutory provisions date from a 1965 Penal Law revision in which the "more sympathetic cases" of assisted suicide were placed within the category of second degree manslaughter, including those cases of "assistance rendered at the request of a person tortured by painful disease." 1965 N.Y. Laws, c. 1030 (codified at N.Y. Penal Law § 125.15(3)); Temporary State Commission on Revision of the Penal Law and Criminal Code, *Proposed New York Penal Law to the Legislative Session of 1964*, at 339 (1964). *See also People v. Duffy*, 79 N.Y.2d 611, 615, 595 N.E.2d 814, 816 (1992) ("section 125.15(3)'s proscription against intentionally causing or aiding a suicide applies even where the defendant is motivated by 'sympathetic' concerns, such as the desire to relieve a terminally ill person from the agony of painful disease") (quoting Temporary State Commission, *supra*).

b. Evolution of New York's Law Through the Work of the New York State Task Force on Life and the Law

In 1985, twenty years after New York's Legislature reaffirmed the sanctions against assisted suicide, then-Governor Mario Cuomo convened the New York State Task Force on Life and the Law to recommend public policy on health care decision-making issues raised by medical advances and new technologies. The work of the Task Force[3] includes a report issued in 1994, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994), in which it specifically addressed whether the legislature should repeal the criminal prohibition against physician assisted suicide. In unanimously rejecting the concept, the Task Force noted that "the distinction between the refusal of medical treatment and

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[3] *See, e.g.*, New York State Task Force on Life and the Law, *When Others Must Choose: Deciding for Patients Without Capacity* (March 1992); New York State Task Force on Life and the Law, *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (July 1987); New York State Task Force on Life and the Law, *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* (April 1986).

assisted suicide and euthanasia has not been well-articulated in the broader public debate" and that the "often-used rubric of the 'right to die' obscures" what it considered to be "critical distinctions." *Id.* at viii. In examining and ultimately rejecting medical proposals to legalize assisted suicide, including one such proposal co-authored by respondent Dr. Timothy Quill, *id.* at 142, the Task Force stated:

> Assisted suicide and euthanasia would carry us into new terrain—American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals . . . are likely to be extraordinary.

Id. at vii-viii. *See also* New York State Task Force on Life and the Law, *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent*, at 41 (July 1987) ("[a]ll the Task Force members believe that as a matter of public policy the taking of human life must not be granted legal sanction").

Subsequent to the issuance of the 1994 Task Force report, and in accordance with the Task Force's consistent recommendation from 1987 to 1994, the New York State Legislature has taken no action to amend or repeal its statutory prohibition against physician assisted suicide. Penal Law Sections 125.15(3) and 120.30 thus remain in the form in which enacted in 1965. *See also* N.Y. Pub. Health Law § 2989(3) (McKinney's 1993) (adopted together with New York's statutory provisions on health care proxies in 1990, and stating

that the health care proxy provisions are "not intended to permit or promote suicide, assisted suicide, or euthanasia").

c. Legitimate State Purposes Underlying New York's Ban on Assisted Suicide

Brushing aside New York's long and considered look at its ban on assisted suicide, including physician assisted suicide, the Second Circuit found the distinction between acts that artificially sustain life and acts that artificially end life to be a distinction without constitutional significance. It then concluded that the State's disparate treatment of the two is unsupported by any legitimate state purpose.

The Second Circuit's equal protection analysis stands in stark contrast to the historical development and legislative history of the challenged penal provisions and the more recent work of the Task Force on Life and the Law. That history and work reflect the State's clear position, as a matter of chosen public policy, that participating in another's suicide, even for humanitarian ends, should not be granted legal sanction. Also clearly evidenced is the reasoned rejection of the view that the choice of a natural death through the withdrawal of artificial life support is either the functional or legal equivalent of a determination to induce death through the use of an outside lethal agent.

Disregarding New York's articulated record in this regard, the Second Circuit found "unequal treatment" of the terminally ill in New York, and then engaged in a rational basis scrutiny of New York's challenged penal provisions, which led it to observe the following:

> But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. *See In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, *cert. denied*, 429 U.S. 922, 97 S. Ct. 319, 50 L. Ed.2d 289 (1976). . . . What concern prompts the state to

> interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," *Planned Parenthood v. Casey*, 505 U.S. 833, 851, 112 S.Ct. 2791, 2807, 120 L. Ed.2d 674 (1992) . . . . The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

Quill, 80 F.3d at 729-30 (3d Cir.).

Despite the court's short answer, state-imposed limitations on the right of self-determination, including a ban on physician assisted suicide, do find a basis in a legitimate state purpose. Indeed, as observed by this Court in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 282, 110 S. Ct. 2841, 2853 (1990):

> [A] State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

Numerous factors justify and make rational, if not compelling, the exercise of a state's police power as embodied in the two New York statutes challenged in this case. They include not only the preservation of life and the prevention of suicide, but also the potential for the abuse of physician assisted suicide and the interest in protecting family members and loved ones; the maintenance of the ethical integrity of the medical profession;[4] and the protection of the interests of innocent third parties. *See, e.g., Compassion in Dying*, 79 F.3d 790, 816 (9th Cir. 1996) (en banc) (listing these, among others, as factors constituting a state's interests); *Eichner v. Dillon*, 73 A.D.2d 431, 465-67, 426 N.Y.S.2d 517, 543-44 (2d

[4] The Hippocratic Oath includes the sentence: "To please no one will I prescribe a deadly drug, nor give advice which may cause his death." STEDMAN'S MEDICAL DICTIONARY 647 (4th Unabridged Lawyers' Ed.) (1976).

Dep't 1980) (same), *modified on other grounds, Matter of Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981). *See also Cruzan*, 497 U.S. at 281, 110 S. Ct. at 2853 ("[i]t cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment"); *Matter of Storar*, 52 N.Y.2d at 377, 420 N.E.2d at 71 ("[t]he State has a legitimate interest in protecting the lives of its citizens. . . . It may, by statute, prohibit them from engaging in specified activities, including medical procedures, which are inherently hazardous to their lives") (citation omitted).

State-imposed limitations on the ability to commit suicide with the aid of a physician are further justified by those reasons of universal application articulated by New York's Task Force on Life and the Law. They include protection of those affected by the "widespread failure of American medicine to treat pain adequately, or to diagnose and treat depression" and the safeguarding of those "whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group." New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, at vii-viii (May 1994).

These salient public concerns are heightened as the medical services delivery system moves toward health maintenance organizations, managed care, group medical practices and the involvement of an array of health care professionals, creating the threshold dilemma of just who decides if and when assisted suicide is morally and medically appropriate. At severe risk are the most vulnerable, including the severely handicapped and the elderly. The potential for irreversible abuse by uncaring relatives or health professionals with their own agendas is enormous.

The court's short answer—"none"—to the legitimate state purpose question resonates unconvincingly against a state's clearly rational interest in legislating to prevent assisted sui-

cide, including physician assisted suicide. Yet with that short answer, the Second Circuit now has essentially created a new substantive right to assisted suicide where one previously did not exist. That right goes far beyond the right to decide on medical treatment and enters the realm of controlling the manner and the timing of death.

d. A "Confused Enterprise" of Legislating

If permitted to stand, the Second Circuit's decision not only brings a legal sea change on an issue of national importance, but portends a "confused enterprise" of legislating, "requiring it to be conducted against a background of federal constitutional imperatives that are unknown because they are being newly crafted from Term to Term." *Cruzan*, 497 U.S. at 293, 110 S. Ct. at 2859 (Scalia, J., concurring).

Significant among the host of unanswered issues left in the decision's wake is the question of whether "terminal illness" is always readily and accurately identifiable and precisely when, and by what definition, a patient should be deemed terminally ill. In a situation where there is no margin for error, it must also be questioned whether an individual's mental state can be known with certainty to be uncompromised by disease, depression, inadequate pain management or the fear and pressures of being a family or social "burden." Corresponding to this determination is the question of who is entitled to judge that the decision to "hasten death" is an "informed" and autonomous one.[5]

[5] Speaking of the presumed collaboration between patients and physicians in "hastening death," the Second Circuit's decision references proposed guidelines for "obitiatrists," i.e., physicians who assist in suicide. *Quill*, 80 F.3d at 731 n.4 (34a-35a) (citing "Doctors Offer Some Support to Kevorkian: Urge 10 Guidelines in Assisting Suicide," N.Y. Times, Dec. 5, 1995, at A21). In a writing entitled MEDICIDE: THE GOODNESS OF PLANNED DEATH (1991), Dr. Jack Kevorkian defines "obitiatry" as the practice of experimentation on living humans while they are under anesthesia and prior to "medicide," *id.* at 202-03, saying:

(footnote continued)

Without constitutional resolution is the additional question of whether the right to receive lethal medications for self-administration includes the right to receive such drugs from medical professionals other than doctors whom the state has authorized to prescribe. An even larger issue is whether a mentally competent terminally-ill patient who is physically unable to self-administer a lethal injection or dosage should—or must—be allowed a physician-administered suicide.

Ultimately, the Second Circuit's finding of an equal protection violation arising out of purported unequal treatment of the terminally ill leads to the following reflection, articulated by the Supreme Court of Michigan in *People v. Kevorkian*:

> In this regard, we observe that a right of personal autonomy cannot exist independent of a recognition of human dignity, and that it would violate the concept of human dignity to measure the value of a person's life by that person's physical and mental condition. *See Cruzan*, 497 U.S. at 282, 110 S. Ct. at 2853. Further, because all persons possess a basic right to personal autonomy, regardless of their physical or mental condition, there would be no principled basis for restricting a right to commit suicide to the terminally ill. The inevitability of death adds nothing to the constitutional analysis.

447 Mich. 436, 470 n.41, 527 N.W.2d 714, 727-28 n.41 (1994), *cert. denied*, 115 S. Ct. 1795 (1995).

Without this Court's review and guidance, the Second Circuit's decision creates an ill-defined new substantive con-

> [M]y ultimate aim . . . is not simply to help suffering or doomed persons kill themselves—that is merely the first step, an early distasteful professional obligation (now called medicide) that nobody in his or her right mind could savor. . . . [W]hat I find most satisfying is the prospect of making possible the performance of invaluable experiments or other beneficial medical acts under conditions that this first unpleasant step can help establish—in a word, obitiatry . . . .

Id. at 214.

stitutional right, brought forth in the name of equal protection, which represents a radical departure from existing medical and legal tradition and places seriously ill patients at immediate risk of fallible judgments and irreversible error. Given the nature of what is at stake and the presence of an issue of exceptional national interest and significance, this Court should grant certiorari to review.

II

THE SECOND CIRCUIT HAS DECIDED AN IMPORTANT FEDERAL QUESTION IN A MANNER THAT CONFLICTS WITH A DECISION OF THE HIGHEST STATE COURT OF MICHIGAN AND WHICH IS AT SIGNIFICANT ODDS WITH THE REASONING OF THE NINTH CIRCUIT ON THE SAME ISSUE

The Second Circuit's decision in this case is in direct conflict with a decision of the Supreme Court of Michigan in *People v. Kevorkian*, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1795 (1995). That case involved five consolidated proceedings, including appeals in several criminal prosecutions brought under Michigan's assisted suicide statute, and an appeal of a civil action brought by a group of terminally ill patients and medical professionals seeking a declaration that Michigan's assisted suicide statute was unconstitutional.

Similar to the Second Circuit, the Supreme Court of Michigan held that "the Due Process Clause of the federal constitution does not encompass a fundamental right to commit suicide, with or without assistance, and regardless of whether the would-be assistant is a physician." *Kevorkian*, 447 Mich. at 482, 527 N.W.2d at 733. However, flatly contrary to the Second Circuit's decision, the Michigan court stated that "persons who opt to discontinue life-sustaining medical treatment are not, in effect, committing suicide," *id.* at 482, 527 N.W.2d at 728, and expressly held:

> For reasons apparent in our analysis of the due process claims, we also reject the argument that Michigan's assisted suicide statute is invalid because it denies equal protection to terminally ill persons who want help in ending their lives, i.e., it denies them a right enjoyed by terminally ill persons who opt to forgo or discontinue life-sustaining medical treatment. As we explained, the two situations are not the same for purposes of constitutional analysis.

Kevorkian, 447 Mich. at 480 n.57, 527 N.W.2d at 732 n.57.[6]

The decision in this case is clearly in conflict with *Kevorkian*. Moreover, the reasoning employed by the Second Circuit in reaching its decision is fundamentally at odds with a recent *en banc* decision of the Ninth Circuit, *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).[7] Brought by four doctors, three patients, and a nonprofit organization called Compassion In Dying, the Washington case presented the Ninth Circuit with what it termed "an extraordinarily important and difficult" issue: "whether a person who is terminally ill has a constitutionally-protected liberty interest in hastening . . . death" and if so, whether the State of Washington might "constitutionally restrict its exercise by banning a form of medical assistance that is frequently requested by terminally ill people who wish to die." *Compassion in Dying*, 79 F.3d at 793. Unlike the Second Circuit, which rejected the physicians' due process claim, the Ninth Circuit, sitting *en banc*, held that insofar as the

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[6] Among the five consolidated cases included in the decision of the Supreme Court of Michigan is *People v. Kevorkian*, No. 93-11482, 1993 WL 603212 (Mich. Cir. Ct. Dec. 13, 1993), in which the equal protection issue was squarely and fully presented and addressed.

[7] Rule 35-3 of the Ninth Circuit's local rules provides that "[i]n appropriate cases, the Court may order a rehearing by the full court following a hearing or rehearing en banc." The Ninth Circuit is currently in the process of deliberating whether to order a rehearing by the full court following its *en banc* decision.

Washington statute prohibits physicians from prescribing life-ending medication for use by terminally ill, competent adults who wish to kill themselves, it violates the Due Process Clause of the Fourteenth Amendment. *Id.*[8]

Kevorkian, *Compassion in Dying*, and this case evidence the legal morass which courts and state legislatures across the country will enter unless the instant petition is granted to provide constitutional guidance from this Court.[9] If various jurisdictions are left in conflict, states encompassed in the Second Circuit, and perhaps the Ninth, may become unwilling meccas for those seeking to secure the assistance of a physician to commit suicide. This would occur, at least in New York, in stark contrast to its long-stated respect for the value of human life, without reference to its condition, and its historical

[8] The Ninth Circuit's *en banc* review declined to address the prior panel's rejection of equal protection arguments. *Compare Compassion in Dying*, 79 F.3d at 798 *with Compassion in Dying v. State of Washington*, 49 F.3d 586, 593 (9th Cir. 1995).

[9] Some thirty-three states have statutes which criminalize assisted suicide. Alaska, Alas. Stat. § 11.41.120(a)(2); Arizona, Ariz. Rev. Stat. Ann. § 13-1103(A)(3); Arkansas, Ark. Code Ann. § 5-10-104(a)(2); California, Cal. Penal Code § 401; Colorado, Colo. Rev. Stat. § 18-3-104(1)(b); Connecticut, Conn. Gen. Stat. Ann. § 53a-56(a)(2); Delaware, Del. Code Ann., tit. 11, § 645; Florida, Fla. Stat. Ann. § 782.08; Georgia, Ga. Code Ann. § 16-5-5(b); Hawaii, Hawaii Rev. Stat. § 707-702(1)(b); Illinois, 720 Ill. Comp. Stat. Ann. 5/12-31; Indiana, Ind. Stat. Ann. § 35-42-1-2.5; Kansas, Kan. Stat. Ann. § 21-3406; Kentucky, Ky. Rev. Stat. 216.302; Louisiana, La. Rev. Stat. Ann. § 14:32.12; Maine, Me. Rev. Stat. Ann., tit. 17-A, § 204; Michigan, Mich. Comp. Laws Ann. § 752.1027; Minnesota, Minn. Stat. Ann. § 609.215; Mississippi, Miss. Code Ann. § 97-3-49; Missouri, Mo. Rev. Stat. § 565.023; Montana, Mont. Code Ann. 45-5-105; Nebraska, Neb. Rev. Stat. § 28-307; New Hampshire, N.H. Rev. Stat. Ann. § 630:4; New Jersey, N.J. Stat. Ann. § 2C:11-6; New Mexico, N.M. Stat. Ann. § 30-2-4; New York, N.Y. Penal Law §§ 120.30 and 125.15(3); North Dakota, N.D. Cent. Code 12.1-16-04; Oklahoma, Okla. Stat. Ann., tit. 21, §§ 813 to 818; Pennsylvania, 18 Pa. Cons. Stat. Ann. § 2505; South Dakota, S.D. Cod. Laws Ann. §§ 22-16-37, 22-16-38; Tennessee, Tenn. Code Ann. § 39-13-216; Texas, Tex. Penal Code Ann. § 22.08; and Wisconsin, Wis. Stat. Ann. § 940.12.

refusal to grant legal sanction to the taking of human life through assisted suicide.

CONCLUSION

Wherefore, for all of the above reasons, petitioners ask that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Second Circuit in this matter.

Dated: New York, New York
May 15, 1996

Respectfully submitted,

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APPENDIX

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 60—August Term, 1995

(Argued: September 1, 1995 Decided: April 2, 1996)

Docket No. 95-7028

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs-Appellants,

—v.—

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants-Appellees.

Before:

MINER and CALABRESI, *Circuit Judges*, and POLLACK, *Senior District Judge*.*

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* The Honorable Milton Pollack of the United States District Court for the Southern District of New York, sitting by designation.

Appeal from summary judgment for defendants entered in the United States District Court for the Southern District of New York (Griesa, Ch. J.) in action to declare unconstitutional two New York statutes penalizing assistance in suicide to extent that the statutes prohibit physicians from acceding to requests of terminally-ill, mentally competent patients for drugs to hasten death.

Affirmed in part and reversed in part.

Judge Calabresi concurs in a separate opinion.

KATHRYN L. TUCKER, Perkins Coie, Seattle, WA, and CARLA A. KERR, Hughes Hubbard & Reed, New York, NY (David J. Burman, Thomas L. Boeder, Kari Anne Smith, Perkins Coie, Seattle, WA, Leigh A. Roveda, Hughes Hubbard & Reed, New York, NY, of counsel), *for Plaintiffs-Appellants*.

MICHAEL POPKIN, Assistant Attorney General, New York, NY (Dennis C. Vacco, Attorney General of the State of New York, Victoria Graffeo, Solicitor General, Kathie Ann Whipple, Acting Bureau Chief, Litigation Bureau, Susan L. Watson, Assistant Attorney General, of counsel), *for Defendants-Appellees*.

MARC FRAZIER SCHOLL, Assistant District Attorney, New York, NY (Robert M. Morgenthau, District Attorney of New York County, Marc Dwyer, Assistant

District Attorney, of counsel), *for Defendant-Appellee Robert M. Morgenthau*.

(Michael L. Costello, New York State Catholic Conference, Albany, NY, Mark E. Chopko, Michael F. Moses, United States Catholic Conference, Washington, DC, of counsel), for United States Catholic Conference and New York State Catholic Conference as *amici curiae*.

(Michael Tierney, New York, NY, of counsel), for New York State Right to Life Committee, Inc. as *amicus curiae*.

(James Bopp, Jr., Richard E. Coleson, Bopp, Coleson & Bostrom, Terre Haute, IN, of counsel), for The National Right To Life Committee, Inc. as *amicus curiae*.

(Paul Benjamin Linton, Clarke D. Forsythe, Americans United for Life, Chicago, IL, of counsel), for Members of the New York State Legislature as *amici curiae*.

(Cameron Clark, Claudia L. Hammerman, New York, NY, of counsel), for Lambda Legal Defense and Education Fund, Inc., National Association of People with AIDS, Unitarian Universalist Association, Americans for Death with Dignity, Death with Dignity Education Center, Gray Panthers Project Fund, Hemlock Society, and Minna Barrett as *amici curiae*.

MINER, *Circuit Judge*.

Plaintiffs-appellants Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman appeal from a summary judgment entered in the United States District Court for the Southern District of New York (Griesa, Ch. J.) dismissing their 42 U.S.C. § 1983 action against defendants-appellees. The action was brought by plaintiffs-appellants, all of whom are physicians, to declare unconstitutional in part two New York statutes penalizing assistance in suicide. The physicians contend that each statute is invalid to the extent that it prohibits them from acceding to the requests of terminally-ill, mentally competent patients for help in hastening death. In granting summary judgment in favor of defendants-appellees, the district court considered and rejected challenges to the statutes predicated upon the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution. *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994). We reverse in part, holding that physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness.

BACKGROUND

The action giving rise to this appeal was commenced by a complaint filed on July 20, 1994. The plaintiffs named in that complaint were the three physicians who are the appellants here and three individuals then in the final stages of terminal illness: Jane Doe (who chose to conceal her actual identity), George A. Kingsley and William A. Barth. The sole defendant named in that complaint was G. Oliver Koppell, then the Attorney

General of the State of New York. He has been succeeded as Attorney General by Dennis C. Vacco, who has been substituted for him as an appellee on this appeal. According to the complaint, Jane Doe was a 76-year-old retired physical education instructor who was dying of thyroid cancer; Mr. Kingsley was a 48-year-old publishing executive suffering from AIDS; and Mr. Barth was a 28-year-old former fashion editor under treatment for AIDS. Each of these plaintiffs alleged that she or he had been advised and understood that she or he was in the terminal stage of a terminal illness and that there was no chance of recovery. Each sought to hasten death "in a certain and humane manner" and for that purpose sought "necessary medical assistance in the form of medications prescribed by [her or his] physician to be self-administered."

The physician plaintiffs alleged that they encountered, in the course of their medical practices, "mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life." Many of these patients apparently "experience chronic, intractable pain and/or intolerable suffering" and seek to hasten their deaths for those reasons. Mr. Barth was one of the patients who sought the assistance of Dr. Grossman. Each of the physician plaintiffs has alleged that "[u]nder certain circumstances it would be consistent with the standards of [his] medical practice" to assist in hastening death by prescribing drugs for patients to self-administer for that purpose. The physicians alleged that they were unable to exercise their best professional judgment to prescribe the requested drugs, and the other plaintiffs alleged that they were unable to receive the requested drugs, because of the prohibitions contained in sections

125.15(3) and 120.30 of the New York Penal Law, all plaintiffs being residents of New York.

Section 125.15 of the New York Penal Law provides in pertinent part:

> A person is guilty of manslaughter in the second degree when:
>
> . . . .
>
> 3. He intentionally . . . aids another person to commit suicide.

A violation of this provision is classified as a class C felony. *Id.*

Section 120.30 of the New York Penal Law provides:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.

A violation of this provision is classified as a class E felony. *Id.*

Count I of the complaint included an allegation that "[t]he Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives." It also included an allegation that

> [t]he Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

Count II of the complaint included an allegation that

> [t]he relevant portions of . . . the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

In their prayer for relief the plaintiffs requested judgment declaring the New York statutes complained of constitutionally invalid and therefore in violation of 42 U.S.C. § 1983 "as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death." Plaintiffs also sought an order permanently enjoining defendants from enforcing the statutes and an award of attorney's fees.

By order to show cause filed on September 16, 1994, the plaintiffs moved for a preliminary injunction to enjoin then-Attorney General Koppell "and all persons acting in concert and participation with him from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths." A declaration by each of the plaintiffs was submitted in support of the application, although Jane Doe had died prior to the filing of the order to show cause. Plaintiffs Kingsley and Barth were then in the advanced stages of AIDS and therefore sought an immediate determination by the district court.

In her declaration, Jane Doe stated:

> I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is

collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural [sic] cavity and it is painful to yawn or cough. . . . In early July 1994 I had the [feeding] tube implanted and have suffered serious problems as a result. . . . I take a variety of medications to manage the pain. . . . It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state. . . . At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. . . . At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.

Mr. Kingsley subscribed to a declaration that included the following:

> At this time I have almost no immune system function. . . . My first major illness associated with AIDS was cryptosporidiosis, a parasitic infection which caused me severe fevers and diarrhea and associated pain, suffering and exhaustion. . . . I also suffer from cytomegalovirus ("CMV") retinitis, an AIDS-related virus which attacks the retina and causes blindness. To date I have become almost completely blind in my left eye. I am at risk of losing my sight altogether from this condition. . . . I also suffer from toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain. . . . I . . . take daily infusions of cytovene for the . . . retinitis condition. This medication, administered for an hour through a Hickman tube which is connected to an artery in my chest, prevents me from ever taking showers and makes simple routine functions burdensome. In addition, I inject my leg daily with neupogen to combat the deficient white cell count in my blood. The daily injection of this medication is extremely painful. . . . At this point it is clear to me, based on the advice of my doctors, that I am in the terminal phase of [AIDS]. . . . It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death when and if my suffering becomes intolerable.

In his declaration, Mr. Barth stated:

> In May 1992, I developed a Kaposi's sarcoma skin lesion. This was my first major illness associated with AIDS. I underwent radiation and chemotherapy to treat this cancer. . . . In September 1993, I was diagnosed with cytomegalovirus ("CMV") in my stomach and colon which caused severe diarrhea, fevers and wasting. . . . In February 1994, I was diagnosed with microsporidiosis, a parasitic infection for which there is effectively no treatment. . . . At approximately the same time, I contracted AIDS-related pneumonia. The pneumonia's infusion therapy treatment was so extremely toxic that I vomited with each infusion. . . . In March 1994, I was diagnosed with cryptosporidiosis, a parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting.

> I have begun to lose bowel control . . . . For each of these conditions I have undergone a variety of medical treatments, each of which has had significant adverse side effects. . . . While I have tolerated some [nightly intravenous] feedings, I am unwilling to accept this for an extended period of time. . . . I understand that there are no cures. . . . I can no longer endure the pain and suffering . . . and I want to have drugs available for the purpose of hastening my death.

A cross-motion for judgment on the pleadings was filed by Attorney General Koppell on October 11, 1994. Thereafter, on October 14, 1994, an amended complaint was filed by the three physicians and Mr. Kingsley naming as defendants Attorney General Koppell and New York State Governor Mario M. Cuomo. The counts of the complaint were the same as set forth in the original complaint, alleging violations of liberty interests guaranteed by the Fourteenth Amendment in Count I and violation of equal protection rights guaranteed by the Fourteenth Amendment in Count II. The prayer for relief remained the same as in the original complaint. Supplemental declarations in support of the plaintiff's motion for preliminary injunction also were filed on October 14, 1994. In their supplemental declarations, Doctors Klagsbrun and Grossman reiterated their desire "to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients to self-administer at the time and place of their choice for the purpose of hastening their impending deaths."

In his supplemental declaration, Dr. Quill declared:

> The removal of a life support system that directly results in the patient's death requires the direct involvement by the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment. It is legally and ethically permitted for physicians to actively assist patients to die who are dependent on life-sustaining treatments. . . . Unfortunately, some dying patients who are in agony that can no longer be relieved, yet are not dependent on life-sustaining treatment, have no such options under current legal restrictions. It seems unfair, discriminatory, and inhumane to deprive some dying patients of such vital choices because of arbitrary elements of their condition which determine whether they are on life-sustaining treatment that can be stopped.

Along with the supplemental declarations filed on October 14th, an original declaration in support of the motion was filed by Dr. Jack Froom, a physician and Professor of Family Medicine with substantial experience in detecting depression in primary care patients. He declared:

> Physicians can determine whether a patient's request to hasten death is rational and competent or motivated by depression or other mental illness or instability. Physicians currently make these determinations as to patient capacity to make end-of-life decisions with respect to orders not to resuscitate and refusal of life-sustaining treatment. . . . Terminally ill persons who seek to hasten death by con-

suming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. . . . Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task. . . . It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice. . . . Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.

A second amended complaint was filed on October 20, 1994. The parties, allegations and prayer for relief were the same as those contained in the first amended complaint, except that Robert M. Morgenthau, District Attorney of New York County, was added as a defendant in his official capacity. Both Dr. Grossman and Dr. Klagsbrun practice medicine in New York City, and Mr. Morgenthau is responsible for the prosecution of crimes occurring in New York County. The physician plaintiffs each filed second supplemental declarations on November 28, 1994, in support of the motion for a preliminary injunction. Each stated that he was currently treating mentally competent, terminally-ill patients who desired to hasten their deaths by self-administering drugs to be provided by the physicians "if and when medically and psychiatrically appropriate." These patients, according to the physicians, understood "their condition, diagnosis, and prognosis and wish[ed] to avoid prolonged suffering by hastening their deaths if and when their

suffering [became] intolerable." None of the three terminally-ill plaintiffs named in the original complaint survived to the date of the district court's decision.

The opinion of the district court was filed on December 16, 1994. The district court denied the motion for a preliminary injunction and granted the defendants' cross motion to dismiss the action, treating the cross motion as one for summary judgment "since the court has considered matters outside the pleadings—*i.e.*, declarations filed on the motion for preliminary injunction." *Quill*, 870 F. Supp. at 79. After finding that the action presented a justiciable case or controversy, the district court first addressed the due process issue. The court determined that physician assisted suicide could not be classified as a fundamental right within the meaning of the Constitution:

> The Supreme Court has described the considerations which are appropriate before there can be a declaration that rights "not readily identifiable in the Constitution's text" are deserving of constitutional protection. Such rights must be implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed. The Supreme Court has also characterized such rights as those liberties that are deeply rooted in the nation's history and traditions.
>
> The trouble is that plaintiffs make no attempt to argue that physician assisted suicide, even in the case of terminally ill patients, has any historic recognition as a legal right.

Id. at 83 (internal citations omitted). Accordingly, the district court concluded "that the type of physician assisted suicide at issue in this case does not involve a

fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment." *Id.* at 84.

Turning to the equal protection issue, the district court identified a reasonable and rational basis for the distinction drawn by New York law between the refusal of treatment at the hands of physicians and physician assisted suicide:

> [I]t is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device. The State has obvious legitimate interests in preserving life, and in protecting vulnerable persons. The State has the further right to determine how these crucial interests are to be treated when the issue is posed as to whether a physician can assist a patient in committing suicide.

Id. at 84-85. Accordingly, the court held "that plaintiffs have not shown a violation of the Equal Protection Clause of the Fourteenth Amendment." *Id.* at 85.

DISCUSSION

I. Justiciability

As they did in the district court, the state defendants contend on appeal that this action does not present a justiciable case or controversy. We reject this contention.

In *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289 (1979), the Supreme Court was faced with a constitutional challenge to an Arizona farm labor statute. The Court stated that, when contesting the constitutionality of a state criminal statute, it is not necessary

that the plaintiff first expose himself to actual prosecution. *Id.* at 298. Rather,

> [w]hen the plaintiff has alleged an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution thereunder, he "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief."

Id. (quoting *Doe v. Bolton*, 410 U.S. 179, 188 (1973)). The Court in *Doe* held that plaintiff physicians had presented a justiciable controversy despite the fact that none had been threatened with prosecution. 410 U.S. at 188. The law that the physicians challenged was a criminal statute that directly criminalized the physician's participation in abortion. Accordingly, a sufficiently concrete controversy was presented.

The same principles lead to the conclusion that there is a case or controversy at issue here. Dr. Quill has had a criminal proceeding instituted against him in the past, and the state nowhere disclaims an intent to repeat a prosecution in the event of further assisted suicides. The other two physician plaintiffs also face the threat of criminal prosecution. Like the physicians in *Doe*, they "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief." Finally, under *Doe*, the physicians may raise the rights of their terminally-ill patients. *See id.*

Although District Attorney Morgenthau argues in his brief on appeal that appellants have not shown that they are in any jeopardy of prosecution in New York County, a recent indictment by a New York County grand jury

demonstrates the contrary. A newspaper report printed on December 15, 1995 disclosed the following:

> Yesterday, District Attorney Robert M. Morgenthau of Manhattan announced that a grand jury had indicted [George] Delury, an editor who lives on the Upper West Side, on manslaughter charges for helping his 52-year-old wife, Myrna Lebov, commit suicide last summer.

Carey Goldberg, *Suicide's Husband Is Indicted; Diary Records Pain of 2 Lives*, N.Y. Times, Dec. 15, 1995, at B1.[1] The physician plaintiffs have good reason to fear prosecution in New York County.

II. Substantive Due Process

Plaintiffs argue for a right to assisted suicide as a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment. This Clause assures the citizenry that any deprivation of life, liberty or property by a state will be attended by appropriate legal processes. However,

> despite the language of the Due Process Clause[ ] of the . . . Fourteenth Amendment[ ], which appears to focus only on the processes by which life, liberty, or property is taken, the cases are legion in which th[at] Clause[ ] ha[s] been interpreted to have substantive content, subsuming rights that to a great extent are immune from . . . state regulation or proscription. Among such cases are those recognizing rights that have little or no textual support in the constitutional language.

[1] On March 15, 1996, Delury pleaded guilty to second-degree attempted manslaughter. Pam Belluck, *Man Will Get Prison Term for Helping His Wife Kill Herself*, N.Y. Times, Mar. 16, 1996, at 23, 26.

Bowers v. Hardwick, 478 U.S. 186, 191 (1986).

Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937). Fundamental liberties also have been described as those that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977); *see also Griswold v. Connecticut*, 381 U.S. 479, 506 (1965) (White, J., concurring). It is well settled that the state must not infringe fundamental liberty interests unless the infringement is narrowly tailored to serve a compelling state interest. *Reno v. Flores*, 113 S. Ct. 1439, 1447 (1993). The list of rights the Supreme Court has actually or impliedly identified as fundamental, and therefore qualified for heightened judicial protection, include the fundamental guarantees of the Bill of Rights as well as the following: freedom of association; the right to participate in the electoral process and to vote; the right to travel interstate; the right to fairness in the criminal process; the right to procedural fairness in regard to claims for governmental deprivations of life, liberty or property; and the right to privacy. 2 Ronald D. Rotunda & John E. Nowak, *Treatise on Constitutional Law* § 15.7, at 434-36 (2d ed. 1992). The right of privacy has been held to encompass personal decisions relating to marriage, procreation, family relationships, child rearing and education, contraception and abortion. *See Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-85 (1977). While the Constitution does not, of course, include any explicit mention of the right of privacy, this right has been recognized as encompassed by the Fourteenth

Amendment's Due Process Clause. *Id.* at 684. Nevertheless, the Supreme Court has been reluctant to further expand this particular list of federal rights, and it would be most speculative for a lower court to do so. *See* Rotunda & Nowak, *Treatise on Constitutional Law*, *supra*, § 15.7, at 433-37.

In any event, the Supreme Court has drawn a line, albeit a shaky one, on the expansion of fundamental rights that are without support in the text of the Constitution. In *Bowers*, the Supreme Court framed the issue as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy and hence invalidates the laws of the many States that still make such conduct illegal and have done so for a very long time." 478 U.S. at 190. Holding that there was no fundamental right to engage in consensual sodomy, the Court noted that the statutes proscribing such conduct had "ancient roots." *Id.* at 192. The Court noted that sodomy was a common law criminal offense, forbidden by the laws of the original 13 states when they ratified the Bill of Rights, and that 25 states and the District of Columbia still penalize sodomy performed in private by consenting adults. *Id.* at 192-93.

As in *Bowers*, the statutes plaintiffs seek to declare unconstitutional here cannot be said to infringe upon any fundamental right or liberty. As in *Bowers*, the right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. *See* Thomas J.

Marzen et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 56-67 (1985). Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 55 (1994) ("*When Death Is Sought*"). Clearly, no "right" to assisted suicide ever has been recognized in any state in the United States. *See generally* Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 561 (1995); Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Rep., May-June 1993, at 32.

In rejecting the due process-fundamental rights argument of the plaintiffs, we are mindful of the admonition of the Supreme Court:

> Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution.

Bowers, 478 U.S. at 194. The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death. We therefore decline the plaintiffs' invitation to identify a new fundamental right, in the absence of a clear direction from the Court whose precedents we are bound to follow. The limited

room for expansion of substantive due process rights and the reasons therefor have been clearly stated: "As a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area.

III. Equal Protection

According to the Fourteenth Amendment, the equal protection of the laws cannot be denied by any State to any person within its jurisdiction. U.S. Const. amend. XIV, § 1. This constitutional guarantee simply requires the states to treat in a similar manner all individuals who are similarly situated. *See* 3 Rotunda & Nowak, *Treatise on Constitutional Law*, *supra*, § 18.2, at 7. But disparate treatment is not necessarily a denial of the equal protection guaranteed by the Constitution. The Supreme Court has described the wide discretion afforded to the states in establishing acceptable classifications:

> The Equal Protection Clause directs that "all persons similarly circumstanced shall be treated alike." But so too, "[t]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." The initial discretion to determine what is "different" and what is "the same" resides in the legislatures of the States. A legislature must have substantial latitude to establish classifications that roughly approximate the nature of the problem perceived, that accommodate competing concerns both public and

> private, and that account for limitations on the practical ability of the State to remedy every ill. In applying the Equal Protection Clause to most forms of state action, we thus seek only the assurance that the classification at issue bears some fair relationship to a legitimate public purpose.

Plyler v. Doe, 457 U.S. 202, 216 (1982) (internal citations omitted and alteration in original).

The general rule, then, is that state legislation carries a presumption of validity if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). In *Cleburne*, the equal protection issue revolved around a zoning ordinance that required a special use permit for homes for the mentally retarded but not for other multiple-dwelling and care-giving facilities. The Supreme Court resolved the issue as follows:

> Because in our view the record does not reveal any rational basis for believing that the Featherston home [for the mentally retarded] would pose any special threat to the city's legitimate interests, we affirm the judgment below insofar as it holds the ordinance invalid as applied in this case.

Id. at 448. In arriving at this conclusion, the Court rejected the city's claims that the disparate classification was justified by the negative attitudes of property owners in the neighborhood of the proposed facility, the location of the facility across the street from a junior high school and on a 500-year flood plain, concerns about legal responsibility for actions that might be taken by the mentally retarded, or concerns about the size of the facility and the number of occupants. *Id.* at 448-50. The Court carefully examined each of these claims

before finding that there was no acceptable reason for the disparate classification in any of them.

Also found invalid under the Equal Protection Clause for failure to survive rational basis scrutiny was a New Mexico statute providing a partial exemption from the state's property tax for certain honorably discharged veterans. *Hooper v. Bernalillo County Assessor*, 472 U.S. 612 (1985). The exemption was limited to veterans who had served on active duty during the Vietnam War for at least 90 continuous days and were New Mexico residents before May 8, 1976. In finding the residence requirement invalid under the Equal Protection Clause, the Court analyzed the New Mexico statute in light of the following principles: "When a state distributes benefits unequally, the distinctions it makes are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive that scrutiny if the distinction rationally furthers a legitimate state purpose." *Id.* at 618 (footnote omitted). The Court determined that the distinction made between veterans who arrived in the state prior to May 8, 1976 and those who arrived thereafter bore no rational relationship to the state's declared objectives of encouraging veterans to settle in the state and of rewarding citizens who resided in the state prior to the cut-off date for their military service. *Id.* at 619-20.

As to the first objective, the Court wrote:

> The distinction New Mexico makes between veterans who established residence before May 8, 1976, and those veterans who arrived in the State thereafter bears no rational relationship to one of the State's objectives—encouraging Vietnam veterans to move to New Mexico. The legislature set this eligibility date long after the triggering event

> occurred. The legislature cannot plausibly encourage veterans to move to the State by passing such retroactive legislation.

Id. at 619 (internal citation omitted). As to the second declared objective, the Court noted that a state court may legitimately compensate resident veterans for past services by providing various advantages, but that "the New Mexico statute's distinction between resident veterans is not rationally related to the State's asserted legislative goal." *Id.* at 621-22. The Court held:

> The State may not favor established residents over new residents based on the view that the State may take care of "its own," if such is defined by prior residence. Newcomers, by establishing bona fide residence in the State, become the State's "own" and may not be discriminated against solely on the basis of their arrival in the State after May 8, 1976.

Id. at 623. *See also Zobel v. Williams*, 457 U.S. 55 (1982) (holding that Alaska statute using length of residence as basis for distribution of oil reserve dividends violated Equal Protection Clause.)

While rational basis scrutiny governs judicial review of the constitutionality of legislation in the areas of social welfare and economics, *see Bowen v. Owens*, 476 U.S. 340, 345 (1986), strict scrutiny is the standard of review where a classification "impermissibly interferes with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class," *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 312 (1976) (footnotes omitted). Suspect classes are those identified by race, alienage or national origin, *Cleburne*, 473 U.S. at 440, and fundamental rights are those explicitly or implicitly derived from the Constitution itself, *see*

San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33-34 (1973). For the reasons described in Part II, *supra*, the New York statutes prohibiting assisted suicide during the terminal stages of illness do not impinge on any fundamental rights nor can it be said that they involve suspect classifications. Laws subject to strict scrutiny will survive such review only if they are suitably tailored to serve a compelling state interest. *Cleburne*, 473 U.S. at 440.

An intermediate level of scrutiny has been applied in analyzing certain equal protection guarantee violations. To pass this scrutiny, the classification must be substantially related to an important governmental objective. *Clark v. Jeter*, 486 U.S. 456, 461 (1988). This sort of examination has been applied to classifications based on sex or illegitimacy. *Id.*; *see also Kadrmas v. Dickinson Pub. Sch.*, 487 U.S. 450, 459 (1988); *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 723-24 (1982). A heightened level of equal protection scrutiny also was applied in *Plyler*, where the Supreme Court struck down a Texas statute withholding from local school districts funding for the education of children not legally admitted into the United States. 457 U.S. at 202.

Applying the foregoing principles to the New York statutes criminalizing assisted suicide, it seems clear that: 1) the statutes in question fall within the category of social welfare legislation and therefore are subject to rational basis scrutiny upon judicial review; 2) New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths; 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and 4) accordingly, to the extent that the statutes in questions prohibit persons in

the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.

The right to refuse medical treatment long has been recognized in New York. In 1914 Judge Cardozo wrote that, under New York law, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129 (1914). In 1981, the New York Court of Appeals held that this right extended to the withdrawal of life-support systems. *In re Eichner* (decided with *In re Storar*), 52 N.Y.2d 363, *cert. denied*, 454 U.S. 858 1981). The *Eichner* case involved a terminally-ill, 83-year-old patient whose guardian ultimately was authorized to withdraw the patient's respirator. The Court of Appeals determined that the guardian had proved by clear and convincing evidence that the patient, prior to becoming incompetent due to illness, had consistently expressed his view that life should not be prolonged if there was no hope of recovery. *Id.* at 379-80. In *Storar*, the companion case to *Eichner*, the Court of Appeals determined that a profoundly retarded, terminally-ill patient was incapable of making a decision to terminate blood transfusions. There, the patient was incapable of making a reasoned decision, having never been competent at any time in his life. *Id.* at 380. In both these cases, the New York Court of Appeals recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so.

The Court of Appeals revisited the issue in *Rivers v. Katz*, 67 N.Y.2d 485 (1986) (establishing the right of mentally incompetent persons to refuse certain drugs). In

that case, the Court recognized the right to bring on death by refusing medical treatment not only as a "fundamental common-law right" but also as "coextensive with [a] patient's liberty interest protected by the due process clause of our State Constitution." *Id.* at 493. The following language was included in the opinion:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Id.

After these cases were decided, the New York legislature placed its imprimatur upon the right of competent citizens to hasten death by refusing medical treatment and by directing physicians to remove life-support systems already in place. In 1987, the legislature enacted Article 29-B of the New York Public Health Law, entitled "Orders Not to Resuscitate." N.Y. Pub. Health Law §§ 2960-79 (McKinney 1993). The Article provides that an "adult with capacity" may direct the issuance of an order not to resuscitate. § 2964. "Order not to resuscitate" is defined as "an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest." § 2961(17). "Cardiopulmonary resuscitation" is defined as "measures . . . to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest." § 2961(4). An elaborate statutory scheme is in place, and it provides, among other things, for surrogate decision-making, § 2965, revocation of consent, § 2969, physician

review, § 2970, dispute mediation, § 2972, and judicial review, § 2973.

In 1990, the New York legislature enacted Article 29-C of the Public Health Law, entitled "Health Care Agents and Proxies." N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993). This statute allows for a person to sign a health care proxy, § 2981, for the purpose of appointing an agent with "authority to make any and all health care decisions on the principal's behalf that the principal could make." § 2982(1). These decisions include those relating to the administration of artificial nutrition and hydration, provided the wishes of the principal are known to the agent. § 2982(2). The agent's decision is made "[a]fter consultation with a licensed physician, registered nurse, licensed clinical psychologist or certified social worker." *Id.* Accordingly, a patient has the right to hasten death by empowering an agent to require a physician to withdraw life-support systems. The proxy statute also presents a detailed scheme, with provisions for a determination that the principal lacks capacity to make health care decisions, for such a determination to be made only by the attending physician in consultation with another physician "[f]or a decision to withdraw or withhold life-sustaining treatment," § 2983, for provider's obligations, § 2984, for revocation, § 2985, and for special proceedings, § 2992, among other matters.

The concept that a competent person may order the removal of life-support systems found Supreme Court approval in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). There the Court upheld a determination of the Missouri Supreme Court that required proof by clear and convincing evidence of a patient's desire for the withdrawal of life-sustaining equipment.

The patient in that case, Nancy Cruzan, was in a persistent vegetative state as the result of injuries sustained in an automobile accident. Her parents sought court approval in the State of Missouri to terminate the artificial nutrition and hydration with which she was supplied at the state hospital where she was confined. The hospital employees refused to withdraw the life-support systems, without which Cruzan would suffer certain death. The trial court authorized the withdrawal after finding that Cruzan had expressed some years before to a housemate friend some thoughts that suggested she would not wish to live on a life-support system. The trial court also found that one in Cruzan's condition had a fundamental right to refuse death-prolonging procedures.

The Missouri Supreme Court, in reversing the trial court, refused to find a broad right of privacy in the state constitution that would support a right to refuse treatment. Moreover, that court doubted that such a right existed under the United States Constitution. It did identify a state policy in the Missouri Living Will Statute favoring the preservation of life and concluded that, in the absence of compliance with the statute's formalities or clear and convincing evidence of the patient's choice, no person could order the withdrawal of medical life-support services.

In affirming the Missouri Supreme Court, the United States Supreme Court stated: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. The Court noted that the inquiry is not ended by the identification of a liberty interest, because there also must be a balancing of the state interests and the individual's liberty interests before there can be a determination that con-

stitutional rights have been violated. *Id.* at 279. The Court all but made that determination in the course of the following analysis:

> Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Id.

The Court went on to find that Missouri allowed a surrogate to "act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death," subject to "a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent." *Id.* at 280. The Court then held that the procedural safeguard or requirement imposed by Missouri—the heightened evidentiary requirement that the incompetent's wishes be proved by clear and convincing evidence—was not forbidden by the United States Constitution. *Id.* at 280-82.

In view of the foregoing, it seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on

life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs. The district judge has identified "a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." *Quill*, 870 F. Supp. at 84. But Justice Scalia, for one, has remarked upon "the irrelevance of the action-inaction distinction," noting that "the cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.' " *Cruzan*, 497 U.S. at 296-297 (citations omitted and alteration in original) (Scalia, J., concurring). *See also* Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2028-31 (1992) (arguing that there is no distinction between assisted suicide and the withholding or withdrawal of treatment).

Indeed, there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in

bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

A finding of unequal treatment does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest. The burden is upon the plaintiffs to demonstrate irrationality. *See Kadrmas*, 487 U.S. at 463. At oral argument and in its brief, the state's contention has been that its principal interest is in preserving the life of all its citizens at all times and under all conditions. But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. *See In re Quinlan*, 70 N.J. 10, 41, *cert. denied*, 429 U.S. 922 (1976). And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992), when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

A panel of the Ninth Circuit attempted to identify some state interests in reversing a district court decision holding unconstitutional a statute of the state of Washington criminalizing the promotion of a suicide attempt. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995).[2] The plaintiffs in the Washington case contended for physician-assisted suicide for the terminally-ill, but the panel majority found that the statute prohibiting suicide promotion furthered the following: the interest in denying to physicians "the role of killers of their patients"; the interest in avoiding psychological pressure upon the elderly and infirm to consent to death; the interest of preventing the exploitation of the poor and minorities; the interest in protecting handicapped persons against societal indifference; the interest in preventing the sort of abuse that "has occurred in the Netherlands where . . . legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient." *Id.* at 592-93. The panel majority also raised a question relative to the lack of clear definition of the term "terminally ill." *Id.* at 593.

The New York statutes prohibiting assisted suicide, which are similar to the Washington statute, do not serve any of the state interests noted, in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment. Physicians do not fulfill the role of "killer" by prescribing drugs to hasten death any more than they do by disconnecting life-support systems. Likewise, "psychological pressure" can be applied just as much upon the elderly and infirm

[2] On rehearing in banc, the Ninth Circuit vacated the decision of the panel and affirmed the decision of the district court. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996) (in banc).

to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death. There is no clear indication that there has been any problem in regard to the former, and there should be none as to the latter. In any event, the state of New York may establish rules and procedures to assure that all choices are free of such pressures. With respect to the protection of minorities, the poor and the non-mentally handicapped, it suffices to say that these classes of persons are entitled to treatment equal to that afforded to all those who now may hasten death by means of life-support withdrawal. In point of fact, these persons *themselves* are entitled to hasten death by requesting such withdrawal and should be free to do so by requesting appropriate medication to terminate life during the final stages of terminal illness.

As to the interest in avoiding abuse similar to that occurring in the Netherlands, it seems clear that some physicians there practice nonvoluntary euthanasia, although it is not legal to do so. *When Death Is Sought*, *supra*, at 133-34. The plaintiffs here do not argue for euthanasia[3] at all but for assisted suicide for terminally-ill, mentally competent patients, who would self-administer the lethal drugs. It is difficult to see how the relief the plaintiffs seek would lead to the abuses found in the Netherlands. Moreover, note should be taken of the fact that the Royal Dutch Medical Associ-

[3] There are those who use the terms "assisted suicide" and "euthanasia" interchangeably. *See* Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y.L. Sch. L. Rev. 439, 439 n.8 (1992). While euthanasia is derived from the Greek words meaning "good death," *id.* at 441, it seems clear that most states, including New York, make a distinction between the two acts. *See When Death Is Sought*, *supra*, at 63. In euthanasia, one causes the death of another by direct and intentional acts. *Id.* Accordingly, euthanasia falls within the definition of murder in New York. *See* N.Y. Penal Law § 125.25(1) (McKinney 1987).

ation recently adopted new guidelines for those physicians who choose to accede to the wishes of patients to hasten death. Under the new guidelines, patients must self-administer drugs whenever possible, and physicians must obtain a second opinion from another physician who has no relationship with the requesting physician or his patient. Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. Times, Sept. 11, 1995, at A3.

Finally, it seems clear that most physicians would agree on the definition of "terminally ill," at least for the purpose of the relief that plaintiffs seek. The plaintiffs seek to hasten death only where a patient is in the "final stages" of "terminal illness," and it seems even more certain that physicians would agree on when this condition occurs. Physicians are accustomed to advising patients and their families in this regard and frequently do so when decisions are to be made regarding the furnishing or withdrawal of life-support systems. Again, New York may define that stage of illness with greater particularity, require the opinion of more than one physician or impose any other obligation upon patients and physicians who collaborate in hastening death.[4]

[4] For example, the state might take steps to assure the competence of prescribing physicians by imposing education and training qualifications, including pain management; it may require the establishment of local ethics committees as resources for physicians faced with questions relating to requests for lethal medications; it could specify the information to be furnished to the patient to ascertain that the patient's choice is a fully voluntary one; it might require consultations with other physicians for further diagnosis and prognosis in regard to the patient's illness, for psychiatric evaluation, and for evaluation of pain control possibilities; it may provide a time delay between a request for lethal medication and the prescription in order to allow a time for reflection; and it may suggest some sort of notification to the patient's family.

Recently, a group of physicians known as "Physicians for Mercy" proposed ten guidelines for doctor-assisted suicide. *Doctors Offer Some Support to Kevorkian: Urge 10 Guidelines in Assisting Suicide*, N.Y. Times, Dec. 5, 1995, at A21. These guidelines call for a physician who assists in suicide, called an "obitiatrist," to refer his patients to a psychiatrist, a specialist in the patient's specific illness, and, if necessary, a specialist in pain management, before acting at the behest of a mentally competent person with an incurable affliction. *Id.* "Physicians for Mercy" has decided to call the practice of physician assisted suicide "patholysis," a term coined by Dr. Jack Kevorkian, who has assisted in more than two dozen suicides. *Id.* However, Dr. Kevorkian's assistance has not been rendered exclusively to those beset by terminal illnesses. Bruce Fein, *The Right to Determine One's Exit from Life*, Wash. Times, Jan. 23, 1996, at A14.

The New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest.

CONCLUSION

We reverse the judgment of the district court and remand for entry of judgment in favor of the plaintiffs in accordance with the foregoing. No costs are awarded to either side. *See* Fed. R. App. P. 39(a).

CALABRESI, *Circuit Judge*, concurring in the result:

The Court today strikes down the New York statutes prohibiting assisted suicide insofar as they apply to "terminally ill, mentally competent patients, who would self-administer drugs." It does so because it finds these statutes to be in violation of the Equal Protection Clause of the Fourteenth Amendment since they are not "ratio-

nally related to a legitimate state interest." *Ante* at 20 (citing *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985)). At the same time, the Court declines to hold that these statutes violate the Due Process Clause of the Fourteenth Amendment, because "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design." *Ante* at 18.

Recently the Ninth Circuit, sitting *en banc*, held that analogous laws violated the fundamental Due Process rights of terminally ill patients. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996) (*en banc*). The Ninth Circuit recognized that Equal Protection arguments for invalidity were "not insubstantial," but did not discuss them in view of its Due Process holding. *Id.* at *39 n.139.

I agree with the Court that these statutes cannot stand. But I do not believe that the history of the statutes, and of New York's approach toward assisted suicide, requires us to make a final judgment under either Due Process or Equal Protection as to the validity of statutes prohibiting assisted suicide. What is not ready for decision ought not to be decided. I would therefore leave open the question of whether, if the state of New York were to enact new laws prohibiting assisted suicide (laws that either are less absolute in their application or are identical to those before us), such laws would stand or fall.

Accordingly, I join the Court's result, but write separately to explain my unwillingness to reach the ultimate Due Process and Equal Protection questions.

I. *A Bit of History*

There once was a time when the law and its judges were not called upon to make choices for human beings lying in the twilight between life and death. In the past, many of these decisions were left to individual doctors and their patients. Sometimes, easing of pain melded, not quite imperceptibly, into more. While doctors did not advertise their availability, there often was an understanding (perhaps unspoken), as patients entered into what usually were long-term relationships with physicians, that when the time came doctors would do what was expected of them. Laws prohibiting assisted suicide were on the books. But whether they were ever meant to apply to a treating physician, or whether such doctors were even slightly concerned about them, is unclear and lost in the shadows of time.[1] And despite a web of statutes, and doctors who, understandably, have become increasingly averse to taking risks and responsibilities, that tradition undoubtedly continues today. As the majority demonstrates, however, this fact is not a prescription for judicial silence. *Ante* at 13-15. We must, therefore,

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[1] *See* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 57 (1994) ("No person has been convicted in New York State of manslaughter for intentionally aiding or causing a suicide. . . . The reluctance to bring such cases no doubt rests in part on the degree of public sympathy [such cases] often arouse, and the resulting difficulty of securing an indictment and conviction."); *Compassion in Dying*, 1996 WL 94848, at *17 (footnotes omitted) ("[T]he mere presence of statutes criminalizing assisting in a suicide does not necessarily indicate societal disapproval. That is especially true when such laws are seldom, if ever, enforced. There is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death. . . . Running beneath the official history of legal condemnation of physician-assisted suicide is a strong undercurrent of a time-honored but hidden practice of physicians helping terminally ill patients to hasten their deaths.").

address petitioners' claim that New York's laws are invalid.

The statutes at issue were born in another age. New York enacted its first prohibition of assisted suicide in 1828. The statute punished any individual who assisted another in committing "self-murder" for first-degree manslaughter. Act of Dec. 10, 1828, ch. 20, 4 1828 N.Y. Laws 19 (codified at N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7 (1829)). This prohibition was tied to the crime of suicide, described by one contemporary New York Court as a "criminal act of self-destruction." *Breasted v. Farmers' Loan & Trust Co.*, 4 Hill 73, 75 (Sup. Ct. 1843), *aff'd*, 8 N.Y. 299 (1853).

English authorities had long declared suicide to be murder. *See* 3 EDWARD COKE, INSTITUTES OF THE LAWS OF ENGLAND 54 (London, E. & R. Brooke 1797) (1644); 1 MATTHEW HALE, PLEAS OF THE CROWN 411-18 (London, E. & R. Nutt 1736) (1680); 4 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND *189 (1769); 3 JAMES FITZJAMES STEPHEN, HISTORY OF THE CRIMINAL LAW OF ENGLAND 104 (1869); William E. Mikell, *Is Suicide Murder?*, 3 COLUM. L. REV. 379, 391 (1903) ("[W]hatever may have been the law before Bracton's time . . . suicide is murder in English law."). And the leading American case echoed these English authorities. *See Commonwealth v. Bowen*, 13 Mass. 356 (1816). In that case, Chief Justice Parker instructed the jury: "Self-destruction is doubtless a crime of awful turpitude; it is considered in the eye of the law of equal heinousness with the murder of one by another. In this offence, it is true the actual murderer escapes punishment; for the very commission of the crime, which the the [sic] law would otherwise punish with its utmost rigor, puts the offender beyond the reach of its

infliction. And in this he is distinguished from other murderers. But his punishment is as severe as the nature of the case will admit; his body is buried in infamy, and in England his property is forfeited to the King." *Commonwealth v. Mink*, 123 Mass. 422, 428 (1877) (reprinting Parker's jury instructions in *Bowen*). *Mink* itself, written by Chief Justice Gray, found that "any attempt to commit" suicide is "unlawful and criminal." *Id.* at 429.

Four years after *Mink*, however, the New York Legislature revised the Penal Code. The new code provided that an intentional *attempt* to commit suicide was a felony with a maximum penalty of two years' imprisonment. Act of July 26, 1881, ch. 676, §§ 174, 178, 3 1881 N.Y. Laws 42-43. But while the Code declared suicide itself to be "a grave public wrong," it imposed no forfeiture because of "the impossibility of reaching the successful perpetrator." *Id.* § 173. The 1881 statute, echoing the earlier 1828 provision, punished assisting a successful suicide as manslaughter in the first degree. *Id.* § 175. The Code also punished assistance in attempted suicide as an unspecified felony. *Id.* § 176.

Whatever may have been the case in other jurisdictions,[2] the 1828 and 1881 statutes prohibited all attempts to assist in a suicide on the theory that such behavior created accessory liability. Thus, because attempted suicide was a crime, assisting in the commission of suicide was also a crime. And the titles of the sections of the 1881 statute manifest these derivative origins; section 175 prohibited "*Aiding* suicide" and section 176 prohibited "*Abetting* an attempt at suicide." *Id.* (emphasis added).[3]

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[2] *See Compassion in Dying*, 1996 WL 94848, at *48-*49 (Beezer, J., dissenting).

[3] The 1937 New York Report of the Law Revision Commission explicitly found that "[t]he history of the [abetting and advising suicide] pro-

Whether these laws applied to a doctor who eased or hastened the death of a terminally ill patient is, of course, quite another matter, and one on which the evidence is scant.[4]

The 1881 scheme was altered in 1919 when the prohibition against attempted suicide (originally found in sections 174 and 178) was removed. Act of May 5, 1919, ch. 414, § 1, 2 1919 N.Y. Laws 1193. The Legislature, nevertheless, left in place the declaration of suicide as a "grave public wrong." *See Hundert v. Commercial Travelers Mut. Accident Ass'n of Am.*, 244 A.D. 459, 460, 279 N.Y.S. 555, 556 (1st Dep't 1935) (per curiam) ("[S]uicide, although recognized as a grave public wrong, is not a crime."). And the prohibition of assisting suicide also remained on the books. But we have found no case in which a physician aiding a person who wished to commit suicide was, in fact, penalized in New York after 1919.

In 1965, the Legislature took the next step and deleted the declaration that suicide was a "grave public wrong."[5]

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vision is traceable into the ancient common law when a suicide or *felo de se* was guilty of a crime punishable by forfeiture of his goods and chattels. One who encouraged or aided him was guilty as an accessory to the crime of 'self-murder'. . . ." STATE OF NEW YORK, REPORT OF THE LAW REVISION COMMISSION FOR 1937, at 830 (1937).

4 *See supra* note 1.

5 The 1965 Act did provide that "[a] person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical injury upon himself may use physical force upon such person to the extent that he reasonably believes it necessary to thwart such result." Act of July 20, 1965, ch. 1030, 1965 N.Y. Laws 2355 (codified at N.Y. Penal Law § 35.10(4)). *See Von Holden v. Chapman*, 87 A.D.2d 66, 68, 450 N.Y.S.2d 623, 626 (4th Dep't 1982) (upholding order authorizing forced feeding of John Lennon's murderer, Mark David Chapman, to prevent Chapman from starving himself to death because "[t]he preservation of life has a high social value in our culture").

It, however, left in place redrafted versions of sections 175 and 176 of the 1881 Code, stating: "A person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide," § 125.15(3), and, "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide," § 120.30.[6]

The years since 1965 have brought further erosion in the bases for prohibiting assisted suicide with respect to terminally ill persons. Thus, in 1981, the New York Court of Appeals declared that "a doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent adult patient to decline medical treatment." *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858 (1981). The court applied this principle both to the withdrawal of life-support and to the refusal of blood transfusions. *Id.* at 379-80. Furthermore, in 1986, the court stated: "In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment . . . ." *Rivers v. Katz*, 67 N.Y.2d 485,

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6 Why the legislature left the prohibition of assisted suicide in the law, and whether it thought about the issue at all is hard to say. The 1937 Law Revision Report had, in a sense, presaged the event when it said that since New York had removed "all stigma [of suicide] as a crime" and that "[s]ince liability as an accessory could no longer hinge upon the crime of a principal, it was necessary to define it as a substantive offense." REPORT OF THE LAW REVISION COMMISSION, *supra* note 3, at 831. The Commission seemed to have been concerned primarily with those who talked others into killing themselves. It noted the important difference between aiding someone who had a mind-set to commit suicide and the "more dangerous" person "working upon the mind of a susceptible person to induce suicide," *id.* at 832.

493, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74, 78 (1986). Lower courts, understandably, followed suit. *See Delio v. Westchester County Medical Ctr.*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987) ("[T]he common-law right of self determination with respect to one's body also forms the foundation for a competent adult patient's right to refuse life-sustaining treatment even if the effect is to hasten death . . . .").

The New York Legislature itself acted accordingly. In the 1987 Orders Not to Resuscitate Act, it provided that an "adult with capacity" may create an "order not to resuscitate" in the event the patient "suffers cardiac or respiratory arrest." Act of Aug. 7, 1987, ch. 818, § 1, 1987 N.Y. Laws 3140 (codified as amended at N.Y. Pub. Health Law, §§ 2960-2979 (McKinney 1993 & Supp. 1996)). In the 1990 Health Care Agents and Proxies Act, it went further and permitted a competent person to designate an agent who has "authority to make any and all health care decisions on the principal's behalf that the principal could make." Act of July 22, 1990, ch. 752, § 2, 1990 N.Y. Laws 1538 (codified as amended at N.Y. Pub. Health Law § 2982(1) (McKinney 1993)). The statute explicitly stated that choices regarding the withdrawal of artificial nutrition and hydration are within the purview of a health care agent when the wishes of the principal are reasonably known to the agent. N.Y. Pub. Health Law § 2982(2).[7]

[7] The 1990 Act provided the following caution: "This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law." N.Y. Pub. Health Law § 2989(3). The full significance of this section is not clear. It understandably limited the agent to doing those acts to which the principal, on whose behalf the agent is acting, could consent. It also seemed to leave in place the *status quo* both as to those acts, like suicide, which were no longer crimes and those, like assisted suicide, which nominally were. But the section did not go further, as New York claims in a letter brief where it says, citing § 2989(3), that "New York's legislature expressly rejected permitting physician assisted suicide." Section 2989(3) did not speak to this any more than it spoke to the legality of suicide.

Later, in 1994, the New York Task Force on Life and the Law, a group organized in 1985 at the request of Governor Cuomo and composed of doctors, bioethicists, and religious leaders, among others, prepared a report on the question. The report, in effect, said leave things as they are: permit suicide and attempted suicide, recognize the right of competent terminally ill patients—either on their own or through agents—to order the ceasing of nutrition and hydration and the withdrawal of life support systems, but do not alter the law to permit what petitioners seek today. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 142-46 (1994). The Legislature received the report and, not surprisingly, took no action, then or since.

From this historical survey, I conclude that 1) what petitioners seek is nominally still forbidden by New York statutes; 2) the bases of these statutes have been deeply eroded over the last hundred and fifty years; and 3) few of their foundations remain in place today.

Specifically:

• The original reason for the statutes—criminalizing conduct that aided or abetted other crimes—is long since gone.

• The distinction that has evolved over the years between conduct currently permitted (suicide, and aiding someone who wishes to die to do so by removing

hydration, feeding, and life support systems) and conduct still prohibited (giving a competent, terminally ill patient lethal drugs, which he or she can self-administer) is tenuous at best.[8]

• The Legislature—for many, many years—has not taken any recognizably affirmative step reaffirming the prohibition of what petitioners seek.

• The enforcement of the laws themselves has fallen into virtual desuetude—not so much as to render the case before us nonjusticiable, but enough to cast doubt on whether, in a case like that which the petitioners present, a prosecutor would prosecute or a jury would convict. And this fact by itself inevitably raises doubts about the current support for these laws.[9]

II. *Constitutional Doubts*

In the case of ordinary legislation none of this would matter much. We regularly uphold laws whose original reason has vanished, whose fit with the rest of the legal system is dubious, whose enforcement is virtually nil, and whose continued presence on the books seems as much due to the strong inertial force that the framers of our constitutions gave to the *status quo* as to any current

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8 *See ante* at 29-34 (the majority opinion's powerful discussion of the weakness of the distinction).

9 We note in passing that a jury in Michigan recently acquitted Dr. Jack Kevorkian after he argued (despite his earlier, quite explicit, publicity and statements) that all he was doing was ending pain. *See* Todd Nissen, *Kevorkian Found Not Guilty in Assisted Suicide Trial*, Reuters, Mar. 8, 1996. We note also that Iowa has just enacted a law forbidding assisted suicide and that this law does not prohibit "the responsible actions of a licensed health professional to administer pain medication to a patient with a terminal illness." *See Gov. Branstad Signs Bill Outlawing Assisted Suicide*, BNA Health Care Daily, Mar. 5, 1996.

majoritarian support. In a different context, I have argued that courts have used subterfuges and aggressive interpretations to rid the system of such laws. *See* GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 163-66, 172-77 (1982). But I have also criticized such judicial action, at least in the absence of express legislative sanction. *See id.; Taber v. Maine*, 67 F.3d 1029, 1039 (2d Cir. 1995).

When legislation comes close to violating fundamental substantive constitutional rights or to running counter to the requirements of Equal Protection, however, there is, as I hope to demonstrate, a long tradition of constitutional holdings that inertia will not do. In such instances, courts have asserted the right to strike down statutes and, before ruling on the ultimate validity of that legislation, to demand a present and positive acknowledgment of the values that the legislators wish to further through the legislation in issue. And so it is to an examination of the substantive constitutional dubiety of the laws before us that I now turn.

There can be no doubt that the statutes at issue come close—at the very least—to infringing fundamental Due Process rights and to doing so in ways that are also suspect under the antidiscrimination principles of the Equal Protection Clause. While differing in emphasis, the various opinions of the Supreme Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), and in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), as well as the *en banc* opinion of the Ninth Circuit in *Companion in Dying*, and the strongly argued majority opinion in this case, make that abundantly clear.

In *Cruzan*, the Court examined whether guardians could order withdrawal of an incompetent patient's life support when, contrary to the requirements of the State of Missouri, there was not clear and convincing proof of the patient's wish to have life support withdrawn. In deciding that the guardians could not so order, the majority opinion noted that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." 497 U.S. at 278. It went on to describe the decision to withdraw life support as "deeply personal" and noted that "[i]t cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment." *Id.* at 281.

Various Justices expanded on this theme. Justice O'Connor, concurring, wrote, "I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, see *ante*, at 278-79, and that the refusal of artificially delivered food and water is encompassed within that liberty interest. See *ante*, at 279." *Id.* at 287. She then added, "Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.* at 289. Justice Brennan, joined by Justices Marshall and Blackmun, dissenting, made a similar point: "Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence." *Id.* at 310-11. In turn, Justice Stevens, also dissenting, powerfully noted: "Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental . . . .' " *Id.* at 343.

Even Justice Scalia, who was the only member of the Court to find that no liberty interest was implicated, recognized that such issues touch the essence of our humanity. He argued that the Constitution was silent on the question of whether one had a liberty interest in refusing life support, and that such a right could not be found in our history and tradition. *Id.* at 293-96 (Scalia, J., concurring). He then went on to say: "Are there, then, no reasonable and humane limits that ought not to be exceeded in requiring an individual to preserve his own life? There obviously are, but they are not set forth in the Due Process Clause. What assures us that those limits will not be exceeded is the same constitutional guarantee that is the source of most of our protection—what protects us, for example, from being assessed a tax of 100% of our income above the subsistence level, from being forbidden to drive cars, or from being required to send our children to school for 10 hours a day, none of which horribles are categorically prohibited by the Constitution. Our salvation is the Equal Protection Clause, which requires the democratic majority to accept for themselves and their loved ones what they impose on you and me." *Id.* at 300. Significantly, as the majority today points out, Justice Scalia also made clear that he recognized no sensible difference between assisted suicide (of the sort involved in the case before us) and assisted removal of life support and feeding tubes.

"[T]he cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.' " *Id.* at 295-97 (Scalia, J., concurring).

Although the Court in *Cruzan* did not ultimately decide whether a patient had a constitutionally protected right to die, the majority opinion clearly recognized that any infringement of such a liberty interest was at least constitutionally suspect.[10] It said, "Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279.

What is more, the Court in *Cruzan* did not merely "assume" that a liberty interest in refusing life-sustaining medical treatment existed. It found that a prohibition of life-support termination would deprive a patient of that liberty interest. In doing so, the Court noted that

[10] Both Justices O'Connor and Scalia joined Chief Justice Rehnquist's opinion, making it an opinion for the Court. Their own concurring opinions, however, gave significantly different glosses to the Court's opinion. *See Cruzan*, 497 U.S. at 287 (O'Connor, J., concurring) ("As the Court notes, the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. See *ante*, at 278-279"); *id.* at 293 (Scalia, J. concurring) ("While I agree with the Court's analysis today, and therefore join in its opinion, I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field . . . .").

"determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry," and that "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Id.* at 279 (internal quotation marks and citation omitted). It then "assumed" that when a patient's liberty interest was balanced against Missouri's interest in life, the balance would come out in favor of the patient.

Cruzan never actually struck this balance, of course, because the Court found that Missouri could insist on strong evidentiary requirements to ensure that Cruzan wanted to die, since "the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment," *id.* at 281. But this in no way undermines *Cruzan*'s holding that in determining whether a patient has a constitutional right to die, we are required to "balance" the consequences of the state's prohibition of life-support termination against the state's interest in preserving life. *Id.* at 279.

Cruzan, therefore, teaches us that statutes that interfere with an individual's decision to terminate life are suspect under the Due Process Clause. The right to act on that decision is one that may or may not receive ultimate constitutional protection, however, depending on the power of the state's interests and the clarity with which those interests are expressed. Moreover, as Justice Scalia in his concurrence points out, the Equal Protection Clause also requires courts to examine whether such statutes apply equally to "you and me"—regardless of whether the prohibited activity interferes with a fundamental right or disadvantages a suspect class.

Like *Cruzan*, *Casey* suggests that New York's assisted suicide statutes are of doubtful constitutionality. In

Casey, the Court noted that "[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education" and that "the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity." 505 U.S. at 851, 849. In this respect, *Casey* borrowed from Justice Harlan's formulation in *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting), 505 U.S. at 848-49, and defined liberty interests to include choices at the core of human existence. Following Harlan, it stated: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence . . . . Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Id.* at 851.

Today's majority and the Ninth Circuit, *en banc*, in *Compassion in Dying*, go further than the Supreme Court did in *Cruzan* and *Casey*. These circuits—the first to rule on the matter—hold that laws prohibiting physicians from assisting suicide in some circumstances actually violate the Constitution. The majority does so because it can see no valid Equal Protection difference between the so-called "passive" assistance that New York allows and the "active" assistance that New York purports to forbid. The Ninth Circuit, instead, finds a violation of a fundamental Due Process right.[11]

[11] And some distinguished scholars agree. *See, e.g.*, Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 794-95 (1989) ("If the decision to live or die is said to be so fundamental to a person that the state may not make it for him, then it is difficult to see on what plausible ground the right to make this decision could be granted to those on life support but denied to all other individuals."). There are, of course, distinguished scholars who disagree. *See, e.g.*, Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 DETROIT MERCY L. REV. 735, 753-60 (1995).

In light of these opinions, I believe that it cannot be denied that the laws here involved, whether tested by Due Process or by Equal Protection, are highly suspect. It is also the case, however, that neither *Cruzan*, nor *Casey*, nor the language of our Constitution, nor our constitutional tradition clearly makes these laws invalid. What, then, should be done?

III. *The Constitutional Remand*

I contend that when a law is neither plainly unconstitutional (because in derogation of one of the express clauses of our fundamental charter or, for that matter, of the more general clauses, as these have been interpreted in our constitutional history and traditions), nor plainly constitutional, the courts ought not to decide the ultimate validity of that law without current and clearly expressed statements, by the people or by their elected officials, of the state interests involved. It is my further contention, that, absent such statements, the courts have frequently struck down such laws, while leaving open the possibility of reconsideration if appropriate statements were subsequently made.

Thus, in *Kent v. Dulles*, 357 U.S. 116, 129 (1958), in striking down a State Department directive limiting citizens' passport rights, the Supreme Court, said: "Where activities or enjoyment, natural and often necessary to the well-being of an American citizen, such as travel, are involved, we will construe narrowly all delegated powers that curtail or dilute them. We hesitate to find in this broad generalized power an authority to trench so heav-

ily on the rights of the citizen. . . . Thus we do not reach the question of constitutionality. We only conclude that § 1185 and § 211a do not delegate to the Secretary the kind of authority exercised here." And in *Greene v. McElroy,* 360 U.S. 474 (1959), in voiding a loyalty-security program that did not provide for confrontation of witnesses, the Court stated: "[Legislative and executive decisions] must be made explicitly not only to assure that individuals are not deprived of cherished rights under procedures not actually authorized, but also because explicit action, especially in areas of doubtful constitutionality, requires careful and purposeful consideration by those responsible for enacting and implementing our laws." *Id.* at 507 (citation omitted)

The same view was expressed even by the great constitutional absolutist, Justice Hugo L. Black. In *Barenblatt v. United States,* 360 U.S. 109 (1959), in dissent, he argued that the authority of the House UnAmerican Activities Committee to investigate communism in education should be limited, "[f]or we are dealing here with governmental procedures which the Court itself admits reach to the very fringes of congressional power. In such cases more is required of legislatures than a vague delegation to be filled in later by mute acquiescence." *Id.* at 139-40 (footnote omitted).[12]

While these earlier cases leaned in part on statutory interpretation or on broad readings of doctrines such as

[12] The Court's opinion in *Kent* and Justice Black's dissent in *Barenblatt* relied in part on a pair of delegation opinions by Chief Justice Hughes dating from the 1930s. These were treated as using a similar approach because, in the 1930s, the statutes at issue were at the fringes of congressional power under the Commerce Clause. *See Kent*, 357 U.S. at 129 (citing *Panama Refining Co. v. Ryan,* 293 U.S. 388, 420-30 (1935)); *Barenblatt*, 360 U.S. at 140 n.7 (Black, J., dissenting) (citing *Panama Refining* and *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495 (1935)).

delegation and vagueness, more recent opinions have applied constitutional remands directly.[13] In *Califano v. Goldfarb,* 430 U.S. 199 (1977), for example, Justice Stevens provided the swing vote in the Court's five-to-four decision that the Social Security Act's grant of special benefits to widows was in violation of Equal Protection. He found that the law discriminated "against a group of males [and] is merely the accidental byproduct of a traditional way of thinking about females." *Id.* at 233 (Stevens, J., concurring). Significantly, he went on to say that "[p]erhaps an actual, considered legislative choice would be sufficient to allow this statute to be upheld, but that is a question I would reserve until such a choice has been made." *Id.* at 223 n.9.[14]

[13] Interpretation to avoid constitutional questions and undue delegation have proven particularly useful to the Supreme Court as ways of sending back for a second look federal statutes that came close to infringing fundamental rights. These devices, however, are either not available or are problematic when the statute that skates close to a constitutional line is a state law, since both what can and cannot be delegated within a state and how a state statute should be interpreted are paradigmatic issues of state law. *Compare Sweezy v. New Hampshire*, 354 U.S. 234, 254 (1957) (plurality opinion applying a concept akin to undue delegation to find that "[t]he lack of any indications that the legislature wanted the information the Attorney General attempted to elicit from petitioner must be treated as the absence of authority. It follows that the use of the contempt power . . . was not in accordance with . . . due process") *with id.* at 257 (Frankfurter, J., concurring in the result) (disagreeing with plurality on this issue because "whether the Attorney General of New Hampshire acted within the scope of the authority given him by the state legislature is a matter for the decision of the courts of that State, as it is for the federal courts to determine whether an agency to which Congress has delegated power has acted within the confines of its mandate"). In such circumstances, a reconsideration can occur at the behest of a federal court only if that court is willing impose a constitutional remand directly. *See infra* (discussion of *Thompson v. Oklahoma*, 487 U.S. 815 (1988), and *Abele v. Markle*, 342 F. Supp. 800 (D. Conn. 1972)).

[14] The other four votes in the majority held that the statute was an invalid discrimination against women. *Califano*, 430 U.S. at 217 (plurality opinion).

The powerful, and telling, concurring opinion by Justice O'Connor in *Thompson v. Oklahoma*, 487 U.S. 815 (1988), which provided the fifth vote to strike down state death penalty laws applicable to minors less than sixteen years of age, did the same thing. The fact that such laws were on the books in many states did not suffice to meet the strictures of the Cruel and Unusual Punishment Clause. The laws may have been there inadvertently or as a result of inertia, and many state legislatures seemed not to have realized that children could be executed under their statutes. Such laws, moreover, were virtually never enforced against minors under sixteen. Hence, the Justice reasoned, they were invalid. But if states reenacted them, consciously and clearly, the Court would then have to consider whether the statutes could actually meet the Clause's requirements. *Id.* at 857 (O'Connor, J., concurring in the judgment).

Perhaps the most dramatic instance of this constitutional remand, or second look, approach occurred in our own Circuit, in a case bearing many similarities to the one before us today. In *Abele v. Markle*, 342 F. Supp. 800 (D. Conn. 1972) ("*Abele I*"), a three-judge district court was asked to examine the constitutionality of a Connecticut statute that banned abortion. Circuit Judge J. Edward Lumbard found the statute to be unconstitutional for reasons later echoed by the Supreme Court in *Roe v. Wade*, 410 U.S. 113 (1973). District Judge T. Emmet Clarie found no violation of due process for reasons akin to those adverted to in today's majority opinion. The key vote was by then-District Judge Jon Newman.

In his landmark opinion, now-Chief Judge Newman found that the Connecticut statute had been passed in 1860 to protect the health of pregnant women, and that

this aim was no longer applicable in 1972 because childbirth endangered a woman's life more than abortion did. *Id.* at 807-09 (Newman, J., concurring). Yet he recognized that other valid grounds for the statute might exist, including, perhaps, the protection of unborn life (*Roe v. Wade* had not yet been decided). Newman pointed out, however, that the statute was not passed to protect unborn life. "If the Connecticut legislature had made [such] a judgment," Newman mused, "the constitutionality of such laws would pose a legal question of extreme difficulty . . . ." *Id.* at 810. Because "that legislative determination has not been shown to have been made," Newman found it "inappropriate to decide the constitutional issue that would be posed" if the Legislature in fact passed a law designed to protect human life. *Id.* And since the statute before him, whatever its basis, raised strong constitutional doubts, Newman nullified the law while explicitly leaving the Legislature free to reconsider the issue.

Judge Newman's opinion is, of course, not binding on us. But it remains an important beacon suggesting what is the correct approach in extremely difficult cases in which neither the Supreme Court, nor constitutional language or tradition, gives clear guidance. It tells us how to deal with situations in which the state interests that might support such statutes can only be inferred from legislative inaction or from long-abandoned legislative motives.

Today, Timothy Quill takes the place of Janice Abele in challenging another statute of nineteenth-century origin. As with the Connecticut abortion law, the rationale for the New York assisted-suicide prohibition has eroded with the passage of time. In the nineteenth century, both suicide and attempted suicide were crimes and assisting

in those crimes was, derivatively, a crime as well. But suicide and attempted suicide are no longer crimes. Nevertheless, the prohibitions on assisted suicide might serve other valid ends. It is possible, for example, to imagine a state in which such statutes were part of an overall approach to the preservation of life that was so all-encompassing that the laws' validity might be upheld despite their infringement of important libertarian individual rights. Our Constitution gives us no more complete dominion over our bodies than it does over our property. *See, e.g., Schmerber v. California*, 384 U.S. 757 (1966) (holding that a state may, over a suspect's protest, have a physician extract blood from a person suspected of drunk driving). In other words, our Constitution does not enact the bodily equivalent of Herbert Spencer's Social Statics. *Cf. Lochner v. New York*, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting). But there is no sign that such an overall "culture of life" reigns in New York State—quite the contrary.

Well before *Roe v. Wade*, New York enacted one of the most permissive abortion laws in the country. *See Roe*, 410 U.S. 113, 147-48 & n.41 (1973). New York recently reenacted the death penalty. *See* Act of Mar. 7, 1995, ch. 1, § 2, 1995 N.Y. Laws 1 (McKinney's) (codified at N.Y. Penal Law § 60.06 (McKinney's Supp. 1996)). As far as I know, no New York Legislature has seriously considered requiring individuals to give their blood, bone marrow or other organs, to keep those who need transplants alive. Indeed, such an idea would strike many as bizarre science fiction. Nearer to hand, the right to demand to die, as and when one wishes, has been recognized in New York for all those on feeding or hydration tubes or on other life support devices. All this the majority opinion demonstrates beyond peradventure.

Various *amici* for the respondents argue that the New York assisted suicide laws consciously adopt their particular vision of what life and death should be. *Amicus* United States Catholic Conference, for example, insists that suicide is antithetical to freedom, that it is not voluntary and that it is linked to psychiatric illness. But there is no reason to believe that New York has accepted these arguments. If it had, one would expect that New York would prohibit attempted suicide and that it would, for example, aggressively discourage suicide by the terminally ill, through legislative declarations defining it to be a "grave public wrong" or through some other means.

Other *amici* contend that the difference between what they call "active" assisted suicide (making lethal drugs available to those terminally ill who would self-administer them) and what they call "passive" behavior (actively removing life supports or feeding tubes, on demand, so that the patient may die) is fundamental. Even if I were to accept the distinction in the face of the powerful arguments made against it both by the majority today and by Justice Scalia in his *Cruzan* concurrence, there is no reason to believe that New York has consciously made such a judgment. Certainly New York has never enacted a law based on a reasoned defense of the difference.

The Attorney General of New York contends that its Legislature has, in fact, made just such a distinction by its inaction, by its failure to remove the prohibitions before us today. It left these in place after the prohibition on what could be called "passive" assisted suicide had been abrogated. Leaving aside the difficulties involved in arguing that legislative *inaction* should be given the *same* weight as legislative *action* in supporting the view that medical *action* and medical *inaction* are funda-

mentally *different*, the argument will not do. As the majority points out, we have not been given any clear statements of possible interests that the state actually believes would be served by the distinction. In their absence, how can we say that the distinction, which is anything but obvious, and which results in severe harm to the ability of some, but not all, individuals to determine crucial life and death choices for themselves, is mandated by the state's fundamental needs? And if the state does not affirmatively tell us what it wishes to put on the other side of the scale, how can we make the balance required by *Cruzan* come out any way but in favor of an individual's freedom to choose between life and death? Whether under Equal Protection, or Due Process, then, the absence of a recent, affirmative, lucid and unmistakable statement of why the state wishes to interfere with what has been held by the Supreme Court to be a significant individual right, dooms these statutes.

I take no position on what I would hold were such an affirmative statement forthcoming from the state of New York. In the wake of *Furman v. Georgia*, 408 U.S. 238, 239-40 (1972) (per curiam), which in effect sent all of the then-existing death penalty laws back for a second look by the states, the Supreme Court (rightly or wrongly) upheld most of the somewhat modified and subsequently enacted death penalty laws. *See Gregg v. Georgia*, 428 U.S. 153, 179-81 (1976) (plurality opinion). Conversely, one month after Judge Newman's concurrence in *Abele I*, Connecticut enacted a new anti-abortion law that was based on protecting the life of the fetus. Pub. Act No. 1, 1972 Conn. Acts 593 (May Spec. Sess.) (codified at Conn. Gen. Stat. § 53-30(a)-(b)). And the same panel that had decided *Abele I* (rightly or

wrongly) declared the new law unconstitutional.[15] Either result is possible after a second look in which the state affirms laws that it previously had allowed to remain in force through passivity or inertia.[16] What I do say is that no court need or ought to make ultimate and immensely difficult constitutional decisions unless it knows that the state's elected representatives and executives—having been made to go, as it were, before the people—assert through their actions (not their inactions) that they really want and are prepared to defend laws that are constitutionally suspect.

It is different when the Constitution speaks clearly. When a law violates the plain mandates of the text, history, or structure of the Constitution, no second look is warranted or appropriate. That law *must* fall. Laws that violate the core of the First Amendment and the core of the Takings Clause are but two examples. When that is not the case, when the Constitution and its history do not clearly render a statute invalid, when its validity depends instead, in part, on the strength of the state interests at

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15 *See Abele v. Markle*, 351 F. Supp. 224, 232 (D. Conn. 1972) ("*Abele II*"). Then-District Judge Newman's opinion noted that, "for the author of this opinion," the Legislature's new "statement of legislative purpose makes the issue posed . . . quite different from the issue raised by the challenge to the prior statutes. . . . A statute of this sort, as I previously indicated [in *Abele I*], 342 F. Supp. at 810 and 811 n.18, poses a far more difficult question, one that I did not believe should be decided unless such a statute was enacted." *Id.* at 226 n.4. Judge Newman's opinion was joined by Judge Lumbard, while Judge Clarie dissented. The Supreme Court subsequently vacated the decision in light of *Roe*, 410 U.S. 951 (1973), and remanded the case to the district court. On remand, the same three judges declared the law unconstitutional. *Abele v. Markle*, 369 F. Supp. 807, 809 (D. Conn. 1973) (per curiam).

16 Sometimes, of course, a legislature will not reenact a statute that has been remanded to it, or will reenact it with modifications and limits sufficient to avoid any serious constitutional challenge.

stake, then a second look is not only appropriate, it is, in my view, usually required.

Without a second look by the people, courts are liable to err in either direction. They may uphold and thereby validate[17] (as they all too often have[18]) the infringement of rights upon which the states did not truly wish to encroach. Conversely, they may, ultimately and definitively, strike down laws, believing that the state interests involved are minor, when in fact these interests turn out to be highly significant.[19]

In the end, a constitutional remand does no more than this: It tells the legislatures and executives of the various states, and of the federal government as well, that if they wish to regulate conduct that, if not protected by our Constitution, is very close to being protected, they must do so clearly and openly. They must, in other words, face the consequences of their decision before the people.[20] Unless they do this, they cannot expect courts

17 *See* CHARLES L. BLACK, JR., THE PEOPLE AND THE COURT: JUDICIAL REVIEW IN A DEMOCRACY 52 (1960) ("[T]he Court, through its history, has acted as the legitimator of the government. In a very real sense, the Government of the United States is based on the opinions of the Supreme Court.").

18 *See* Guido Calabresi, *The Supreme Court, 1990 Term—Foreword: Antidiscrimination and Constitutional Accountability (What the Bork-Brennan Debate Ignores)*, 105 HARV. L. REV. 80, 143-45 (1991).

19 *See* Harry Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 YALE L.J. 221 (1973); Alexander Bickel & Harry Wellington, *Legislative Purpose and the Judicial Process: The* Lincoln Mills *Case*, 71 HARV. L. REV. 1 (1957); Alexander Bickel, *The Supreme Court, 1960 Term—Foreword: The Passive Virtues*, 75 HARV. L. REV. 40 (1961).

20 In this respect, the notion of a constitutional remand may respond to some of the concerns expressed by the dissenters in *Companion in Dying*. *See Compassion in Dying*, 1996 WL 94848, at *60 (Beezer, J. dissenting) ("Whether the charitable or uncharitable characterization [of physician-assisted suicide] ultimately prevails is a question that must be

to tell them whether what they may or may not actually wish to enact is constitutionally permitted.

IV. *Conclusion*

For all of the above reasons, I do not reach the merits in this case—merits that are, as Judge Newman said of those that he also did not reach in *Abele v. Markle*, "of extreme difficulty." 342 F. Supp. at 810. What, after all, are we to make of Margaret Mead's statement, cited in one of the *amicus* briefs, that we should beware of giving those who have the power to heal the right to kill, since anthropologically speaking the distinction between the two is relatively new in our cultures? It is certainly worth pondering. But how does it help us to distinguish between giving doctors the right to remove life support systems and the right of the terminally ill to demand lethal drugs from the same doctors? And how is one to weigh petitioners' claim that if doctors are not allowed to give patients lethal drugs for self-administration, those patients will be forced to commit suicide, legally,

resolved by the people through deliberative decisionmaking in the voting booth . . . This issue we, the courts, need not—and should not—decide. . . . To declare a constitutional right to physician-assisted suicide would be to impose upon the nation a repeal of local laws."); *id.* at 61 (Fernandez, J., dissenting) ("Like so many other issues, it is one 'for the people to decide.' Our Constitution leaves it to them; it is they and their representatives who must grapple with the riddle and solve it.") (citation omitted); *id.* at 61 (Kleinfeld, J., dissenting) ("The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary. . . . That an issue is important does not mean that the people, through their democratically elected representatives, do not have the power to decide it."). *See also* 1 BRUCE ACKERMAN, WE THE PEOPLE: FOUNDATIONS (1991); CAN. CONST. (Constitution Act, 1982), pt. I (Canadian Charter of Rights and Freedoms) § 33 (containing the *Non-Obstante* Clause that permits legislature to abrogate rights, but only if the legislature explicitly decides to do so).

in far more horrendous ways—by hanging, shooting, or gassing themselves? These methods, petitioners assert, are plausibly more dangerous to society and devastating to survivors. But is it really the case that terminally ill patients would take such measures? And which way would it cut, if they did not? These questions, moreover, hardly begin to approach the human tragedies, and the deeply held beliefs, that the issues we would have to decide would require us to explore. No. Unless New York forces us to face such choices head on, by asserting its interest in the prohibitions before us, we should not do so. And this New York has not done.

I would hold that, on the current legislative record, New York's prohibitions on assisted suicide violate both the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the United States Constitution to the extent that these laws are interpreted to prohibit a physician from prescribing lethal drugs to be self-administered by a mentally competent, terminally ill person in the final stages of that terminal illness. I would, however, take no position on whether such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves. I therefore concur in the result reached by the Court.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants.

OPINION

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GRIESA, *Chief Judge*

New York law makes it a crime to aid a person in committing suicide, or in attempting to commit suicide. Plaintiffs urge that these provisions violate the United States Constitution, to the extent that they apply to situations where a physician aids the commission of suicide by a mentally competent, terminally ill adult wishing to avoid continued severe suffering, by prescribing a death-producing drug which the patient takes. Plaintiffs claim that a person has a constitutional right to terminate his life under these circumstances, and that a physician has a corresponding constitutional right not to be prosecuted for aiding a patient in the exercise of the patient's right.

Plaintiffs move for a preliminary injunction against the enforcement of the relevant statutes, §§ 125.15(3) and 120.30 of the New York Penal Law, to the extent they apply to physicians who give the kind of assistance described above. Defendants oppose plaintiffs' motion and cross-move for judgment on the pleadings dismissing the action.

Plaintiffs' motion for preliminary injunction is denied. Defendants' cross-motion to dismiss the action is granted. The motion to dismiss will be treated as one for summary judgment since the court has considered matters outside the pleadings—*i.e.*, declarations filed on the motion for preliminary injunction. There is no dispute on the essential facts and the issues presented are ones of law.

The Parties

The action was commenced on July 20, 1994. The original complaint named three physician plaintiffs, Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman. There were also three patient plaintiffs who asserted that they were terminally ill and wished to have the assistance of physicians in committing suicide. All three of the patient plaintiffs have now died, leaving only the three physician plaintiffs.

The original complaint named only the Attorney General of the State of New York as a defendant. However, it was argued that the Attorney General was not the proper defendant because he was not responsible for prosecutions under the criminal laws of the State. The complaint has now been amended to add as defendants Governor Mario M. Cuomo and New York County District Attorney Robert M. Morgenthau. There is no longer any question about the fact that there are sufficient defendants present to allow the issues in the case to be litigated.

Amicus curiae briefs in opposition to plaintiffs' position have been filed by the New York State Catholic Conference and the Legal Center for the Defense of Life.

The Relevant Record

The Original Complaint

The original complaint of July 20, 1994 contained, among other things, allegations that the three patient plaintiffs were mentally competent adults; that they were in the terminal stages of fatal illnesses; that they faced progressive loss of bodily function and integrity as well as increasing suffering; and that they desired medical assistance in the form of medications prescribed by physicians to be self-administered for the purpose of hastening death.

As to the three physician plaintiffs, the complaint alleged that, in the regular course of their medical practice, they

treated terminally ill patients who requested assistance in the voluntary self-termination of life; that under certain circumstances it would be consistent with the standards of these physicians to prescribe medications to such patients which would cause death, since without such medical assistance these patients could not hasten their deaths in a certain and humane manner.

The original complaint alleged that the patient plaintiffs have a constitutional right under these circumstances to terminate their lives with this type of medical assistance; and that since the New York Penal Law makes it a crime to render such assistance, these provisions violate the constitutional rights of both the patient plaintiffs and the physician plaintiffs, specifically rights under the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

Amendments to the Complaint

An amended complaint was filed on October 14, 1994. By this time, two of the three patient plaintiffs had died. The allegations about the remaining patient plaintiff were carried over into the amended complaint, as were the claims of the physician plaintiffs.

The second amended complaint was filed October 20, 1994. It was essentially the same as the previous complaint except for naming New York County District Attorney Robert M. Morgenthau as a defendant.

Subsequently, the third patient plaintiff died, thus leaving the three physicians as the only plaintiffs.

An answer was filed in August 1994 to the original complaint denying that plaintiffs have any valid claim. No amended answers were filed responding to the amended complaints, but the court deems the original answer to be a sufficient denial of plaintiffs' claims.

Declarations Filed on Motion For Preliminary Injunction

The motion for preliminary injunction was filed on September 16, 1994. In support of the motion, each of the three patient plaintiffs submitted declarations which confirmed the allegations in the complaint and added details about their diseased conditions and suffering.

The three physician plaintiffs have submitted declarations affirming their belief that proper and humane medical practice should include the ability to prescribe medication which will enable a patient to commit suicide under the circumstances described in this case.

A declaration by Quill also describes the following incident. In 1990 he treated a terminally ill patient, who feared a lingering death and who apprised Quill that she would act on her own to hasten death if he refused to assist her to do so. Quill made barbiturates available to the patient, which she could use to induce sleep, but which she could also take to end her life by an overdose at the point she desired to do so. She agreed to meet with Quill prior to taking any overdose. The patient reached the point where she desired to end her life. She met with Quill "to insure that all alternatives had been explored," after which she took the overdose and died. Quill was not present at the time of death. Subsequently, Quill wrote an article in the New England Journal of Medicine describing these events. This led to what Quill describes as a "very public criminal investigation" in New York State, and presentation to a grand jury. Quill testified before the grand jury, as did other witnesses. The grand jury did not indict.

The other two physician plaintiffs, Klagsbrun and Grossman, describe in their declarations specific incidents when terminally ill patients wished assistance in hastening death. Each doctor asserts that he refrained from rendering such assistance because of possible prosecution under the New York statutes.

The Statutes

Section 125.15(3) of the New York Penal Law provides in relevant part:

> A person is guilty of manslaughter in the second degree when:
>
> . . .
>
> 3. He intentionally . . . aids another person to commit suicide.

Section 120.30 provides:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.

Violation of either statute is a felony.

Plaintiffs are not seeking to strike down these statutes in their entirety. Plaintiffs claim that the statutes are unconstitutional only insofar as they apply to the type of physician assisted suicide at issue in this case. Both plaintiffs and defendants agree that, if a physician renders the type of assistance described here, he will violate § 125.15(3) where actual death by suicide occurs, and § 120.30 where the patient attempts to commit suicide and fails.

DISCUSSION

Justiciability

Defendants assert that there is no justiciable case or controversy as required by Article III of the Constitution. According to defendants, plaintiffs show nothing more than a speculative possibility of prosecution, rather than any actual threat of prosecution.

The court does not agree with these assertions. The relevant law is well set forth in *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289 (1979). There the Supreme Court dealt

with a constitutional challenge to certain Arizona agricultural labor regulations. The case was brought by a union and parties connected with the union. The Court held that certain of the plaintiffs' claims were justiciable and certain were not. The Court stated that when contesting the constitutionality of a criminal statute it is not necessary that the plaintiff first expose himself to actual prosecution. When the plaintiff has alleged an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution, a sufficient controversy is presented. On the other hand, where there are no fears of prosecution except those which are imaginary or speculative, there is no basis for federal court action. "Abstract questions" are not justicible. *Id.* at 297-99.

In *Babbitt* the Court upheld federal jurisdiction over claims where (1) the plaintiffs asserted both the intention and the constitutional right to engage in conduct which would violate the regulations, and (2) the state had not disavowed the intention of imposing criminal penalties. Thus the plaintiffs were "not without some reason in fearing prosecution," and the positions of the parties were "sufficiently adverse" to present a proper case. *Id.* at 302-3.

As to the claims in *Babbitt* held not to be justiciable, the Court found that it was uncertain whether the particular activities involved would actually give rise to a problem under the regulations. The factual pattern which might develop was unclear. *Id.* at 303-4.

Another instructive case is *Doe v. Bolton*, 410 U.S. 179 (1973). This was a companion abortion case to *Roe v. Wade*, 410 U.S. 113 (1973). In *Doe*, the plaintiffs challenged the Georgia anti-abortion statute. The Court held, among other things, that the claim of the physician plaintiffs presented a justiciable controversy. This was true despite the fact that none of them had been prosecuted or threatened with prosecution. The Court pointed out, 410 U.S. at 188:

> The physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief.

On the basis of these authorities, the court holds that the instant case presents a justiciable controversy under Article III of the Constitution. The three physician plaintiffs seek to carry on activities which they contend are within their constitutional rights and which would violate the New York Penal Law. This is not a case about some activity in which a plaintiff might possibly engage and which might create a hypothetical issue of criminal liability. The physician plaintiffs credibly assert that they have had cases and continue to have cases in which their services are urgently sought to assist in the commission of suicide in the way described in this case. As to whether there is a threat of prosecution for so assisting, there has been the grand jury proceeding about plaintiff Quill. Although no indictment was returned, the State has by no means disavowed the intention of acting against physicians in future cases. Indeed, the State has in the present action vigorously defended its right to apply the statutes to such conduct. Thus, there is a credible threat of prosecution giving rise to sufficiently adverse positions so that a justiciable controversy exists. What is presented here is no mere abstract question.

This is particularly true since the issue of physician assisted suicide is being pressed by segments of the medical community and has sparked sharp public debate. It is most unlikely that the conduct at issue in this case would be ignored by the law enforcement authorities.

It is appropriate to note that the primary right claimed is that of the patient—*i.e.*, the right to decide to terminate one's life and to do so by suicide. However, if such a constitutional right resides in the patient, then there would be a corresponding constitutional right of the physician not to be prosecuted for assisting in the exercise of the patient's con-

stitutional right. The physician plaintiffs in the present case have standing to raise the whole range of issues—both as to the patient's asserted right to terminate his life and the physician's right to be free from prosecution for rendering assistance. *See Doe*, 410 U.S. at 188.

The Due Process Issue

The Fourteenth Amendment provides that no state may "deprive any person of life, liberty, or property, without due process of law." It is now established that there are certain subjects which are so fundamental to personal liberty that governmental invasion is either entirely prohibited or sharply limited. One recent articulation of this concept by the Supreme Court, which is strongly relied upon by plaintiffs, is contained in the plurality opinion in *Planned Parenthood v. Casey*, 112 S.Ct. 2791, 2807 (1992).

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family-relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Casey confirmed the holding in *Roe v. Wade* that the Fourteenth Amendment protects a woman's decision to abort a pregnancy in the pre-viability stage.

Plaintiffs also rely on the Supreme Court decision in *Cruzan v. Director Missouri Dep't of Health*, 497 U.S. 261 (1990). In that case a woman suffered an accident, after which she could only be kept alive by artificial feeding and hydration. She lost her cognitive faculties, and apparently had no possibility of recovery. Her parents desired to have the life-sustaining apparatus withdrawn. The Supreme Court of Missouri held that it was necessary, before such a step could be taken, to show by clear and convincing evidence that the injured woman would have desired withdrawal of the medical devices, and further held that such evidence was lacking.

Although the United States Supreme Court, in reviewing the case, did not provide a single convenient statement of the question before it, a fair summary of the issues would appear to be whether the injured woman had a constitutional right requiring the hospital to withdraw life-sustaining treatment; whether this right could be exercised on behalf of the woman by her parents; and whether the exercise of this right was unduly hampered by the evidence rule imposed by the state court. In approaching these questions the Supreme Court stated:

> The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.

Id. at 278. The Court went on to discuss the specific issue of whether this general right to refuse treatment would apply where such refusal might lead to death.

> Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent

person a constitutionally protected right to refuse life-saving hydration and nutrition.

Id. at 279. Thus, the Court stopped short of actually deciding that there is a constitutional right to terminate medical treatment necessary to sustain life, although the Court *assumed* the existence of such a right for the purpose of going on to the other issues in the case. As to these, the Court held that the state had the power to require evidence of the patient's wishes rather than allowing the decision solely at the behest of family members, and that the state could properly require proof of the patient's wishes by clear and convincing evidence.

Plaintiffs in the present case argue that the reasoning and holdings of the Supreme Court in *Roe* and *Casey* are broad enough to establish that there is a fundamental right on the part of a terminally ill patient to decide to end his life, and to do so with the type of assistance described in this case. Plaintiffs also interpret the *Cruzan* decision as being tantamount to a holding that a terminally ill person has a constitutional right to require the withdrawal of life-sustaining treatment. Plaintiffs argue that it follows inevitably that there is a constitutional right of physician assisted suicide under the circumstances and in the manner at issue here.

Plaintiffs' reading of these cases is too broad. The Supreme Court has been careful to explain that the abortion cases, and other related decisions on procreation and child rearing, are not intended to lead automatically to the recognition of other fundamental rights on different subjects. *See, e.g., Bowers v. Hardwick*, 478 U.S. 186, 191 (1986); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68, n.15 (1973). With regard to *Cruzan*, as already described, the Court did not actually make the holding upon which plaintiffs seek to rely. In any event, it would appear clear that suicide has a sufficiently different legal significance from requesting withdrawal of treatment so that a fundamental right to suicide cannot be implied from *Cruzan*.

The Supreme Court has described the considerations which are appropriate before there can be a declaration that rights

"not readily identifiable in the Constitution's text" are deserving of constitutional protection. *See Bowers*, 478 U.S. at 191. Such rights must be implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed. The Supreme Court has also characterized such rights as those liberties that are deeply rooted in the nation's history and traditions. *Id.* at 191-92. *See also Moore v. East Cleveland*, 431 U.S. 494, 503 (1977).

The trouble is that plaintiffs make no attempt to argue that physician assisted suicide, even in the case of terminally ill patients, has any historic recognition as a legal right. The history of the treatment of suicide by the law has been dealt with in a number of recent studies. *See, e.g.*, Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 17-100 (1986); Note, *Physician-Assisted Suicide and New York Law*, 57 Alb. L. Rev. 819, 824-32 (1994); The New York State Task Force on Life and The Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 54-56 (1994). Justice Scalia's concurring opinion in *Cruzan*, 497 U.S. at 294-95, also contains a useful historical summary.

Suicide was a crime under English common law, even if the motive was to avoid suffering and illness. Obviously, no punishment could be inflicted upon the deceased, but sanctions were imposed by way of forfeiture of property and ignominious burial. The American colonies apparently adopted this common law rule, but it has been gradually abandoned so that no state in this country now criminalizes suicide or attempted suicide. However, as Justice Scalia states, this change in the law resulted from a desire "to spare the innocent family and not to legitimatize the act." *Cruzan*, 497 U.S. at 294.

As to assisting suicide, the majority of states in this country have long imposed criminal penalties on one who aids another in committing suicide. *See Cruzan*, 497 U.S. at 280 (majority opinion). The Model Penal Code, adopted by the American Law Institute, provides that it is a crime to assist a suicide. *Model Penal Code* § 210.5(2) and comment at 100 (American Law Institute 1980). The comment states:

> Self destruction is surely not conduct to be encouraged or taken lightly. The fact that penal sanctions will prove ineffective to deter the suicide itself does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or induce another to take his own life. Moreover, in principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request of the suicide victim.

Plaintiffs are, of course, suggesting a limited form of physician assisted suicide. But plaintiffs have pointed to nothing in the historical record to indicate that even this form of assisted suicide has been given any kind of sanction in our legal history which would help establish it as a constitutional right.

For these reasons, the court holds that the type of physician assisted suicide at issue in this case does not involve a fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment.

The Equal Protection Issue

Plaintiffs contend that even if there is no fundamental right to engage in assisting a patient's suicide under the Due Process Clause, they should prevail under the Equal Protection Clause. Their argument proceeds thus. It is established under New York law that a competent person may refuse medical treatment, even if the withdrawal of such treatment will result in death. *See, e.g., Rivers v. Katz*, 67 N.Y.2d 485, 493, 504 N.Y.S.2d 74, 78, 495 N.E.2d 337 (1986); *In Re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64 (1981); *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

Plaintiffs further argue that such refusal of treatment is essentially the same thing as committing suicide with the advice of a physician. Plaintiffs urge that for the State to sanction one course of conduct and criminalize the other involves discrimination which violates the Equal Protection Clause of the Fourteenth Amendment.

The issue is whether the distinction drawn by New York law has a reasonable and rational basis. *Dandridge v. Williams*, 397 U.S. 471, 485, 487 (1969). To certain ways of thinking, there may appear to be little difference between refusing treatment in the case of a terminally ill person and taking a dose of medication which leads to death. But to another way of thinking there is a very great difference. In any event, it is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device. The State has obvious legitimate interests in preserving life, and in protecting vulnerable persons. The State has the further right to determine how these crucial interests are to be treated when the issue is posed as to whether a physician can assist a patient in committing suicide. Clearly in the present public debate there are sincere and conscientious advocates for and against the concept of physician assisted suicide. Under the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State.

For these reasons the court holds that plaintiffs have not shown a violation of the Equal Protection Clause of the Fourteenth Amendment.

It should be noted that one federal district court has taken a view contrary to what is expressed in this opinion as to both the due process and the equal protection issues. *Compassion in Dying v. Washington*, 850 F. Supp. 1455 (W.D. Wash. 1994). That ruling is on appeal to the Ninth Circuit.

CONCLUSION

Plaintiffs' motion for a preliminary injunction is denied. Defendants' motion to dismiss, treated as a motion for summary judgment, is granted, and the action is dismissed.

SO ORDERED.

Dated: New York, New York
December 15, 1994

/s/ THOMAS P. GRIESA
Thomas P. Griesa
U.S.D.J.

Supreme Court, U.S.
FILED
JUN 17 1996
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No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Should this Court grant certiorari to decide whether the Fourteenth Amendment's Equal Protection Clause is violated by New York laws that permit only one class of mentally competent, terminally ill patients to choose to hasten death with medical assistance — those on life support — when there is no conflict among federal courts or between a federal court and a state court of last resort on this issue, when the law continues to be developed by the lower courts, and when the court below properly applied equal protection principles?

CONTENTS

Page

QUESTION PRESENTED i

STATEMENT OF THE CASE 1

FACTUAL BACKGROUND 2

I. RESPONDENT DOCTORS AND THEIR PATIENTS 2

II. THE ASSISTANCE SOUGHT BELOW VS. THE ASSISTANCE NEW YORK PERMITS 3

III. THE LOWER COURTS' DECISIONS 5

REASONS FOR DENYING THE PETITION 6

I. THERE IS NO CONFLICT AMONG THE LOWER COURTS 6

A. There Is No Conflict Between Federal Circuits 6

B. There Is No Conflict Between a Federal Court and a State Court of Last Resort 7

II. REVIEW BY THIS COURT AT THIS TIME IS PREMATURE 9

III. THE SECOND CIRCUIT CORRECTLY DECIDED THAT NEW YORK PENAL LAW SECTIONS 125.15(3) AND 120.30 DENY EQUAL PROTECTION 10

A. New York Law Grants Broad Patient Autonomy Over End-of-Life Decisions 11

1. Mental Competence 13

2. Terminal Illness 14

3. Physician Assistance in the Form of Prescriptions 15

4. Patient Choice 16

5. Self-Administration of Drugs 17

6. Hastening One's Own Death 19

B. The Challenged Laws Deny Equal Protection 21

CONCLUSION 22

TABLE OF AUTHORITIES

Page

Cases

Brophy v. New England Sinai Hospital, Inc., 497 N.E.2d 626 (Mass. 1986) 18

California ex. rel. Cooper v. Mitchell Bros.' Santa Ana Theater, 454 U.S. 90 (1981) 9

City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985) 21

Compassion In Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc) 6

Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990) 17, 19

Delio v. Westchester County Medical Ctr., 516 N.Y.S.2d 677 (N.Y. App. Div. 1983) 16

Doe v. Bolton, 410 U.S. 179 (1973) 3

Erickson v. Dilgard, 252 N.Y.S.2d 705 (N.Y. Sup. Ct. 1962) 15

F.S. Royster Guano Co. v. Virginia, 253 U.S. 412 (1920) 21

Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990) 15, 20, 21

Gilliard v. Mississippi, 464 U.S. 867 (1983) 9

Granfinanciera, S.A. v. Nordberg, 492 U.S. 33 (1989) 22

Hobbins v. Michigan, No. 94 (Oct. Term 1994) 9

Maryland v. Baltimore Radio Show, Inc., 338 U.S. 912 (1950) 10

McCray v. New York, 461 U.S. 961 (1983) 9

McIver v. Krischer, CL96-1504AF, Palm Beach Circuit Court, 15th Judicial Circuit, Florida 9

People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995) 7

Plyler v. Doe, 457 U.S. 202 (1982) 21

Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) 6, 7, 14

Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986) 12, 16

Romer v. Evans, 64 U.S.L.W. 4353, 1996 U.S. LEXIS 3245 (May 20, 1996) 21

Schloendorff v. Society of N.Y. Hosp., 105 N.E. 92 (N.Y. 1914) 12

Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) 20

United States v. Carver, 260 U.S. 482 (1923) 10

Washington v. Yakima Indian Nation, 439 U.S. 463 (1979) 22

Statutes

1995 Mi. SB 452 § 2(e) 8

1996 Mi. ALS 193 8

1996 Mi. P.A. 193 8

42 U.S.C. 1395x(dd)(3)(A) 14

Mich. Comp. Laws § 700.496(9)(e) 8

Mich. Comp. Laws § 752.1027 8

N.Y. Penal Law § 120.30 ..... 2, 10, 22

N.Y. Penal Law § 125.15(3) 2, 10, 22

N.Y. Pub. Health Law § 2504(1) 15

N.Y. Pub. Health Law § 2803-c(3) 16

N.Y. Pub. Health Law § 2961(23) 14

N.Y. Pub. Health Law § 2961(3) 13

N.Y. Pub. Health Law § 2963(1) 13

N.Y. Pub. Health Law § 2963(3)(a) 14

N.Y. Pub. Health Law § 2964(1) 11

N.Y. Pub. Health Law § 2964(2) 8, 11

N.Y. Pub. Health Law § 2964(3) 11

N.Y. Pub. Health Law § 2965(3)(a) 16

N.Y. Pub. Health Law § 2965(3)(c)(iv) 11

N.Y. Pub. Health Law § 2973(1) 16

N.Y. Pub. Health Law § 2976 11

N.Y. Pub. Health Law § 2976(1) 16

N.Y. Pub. Health Law § 2980(3) 13

N.Y. Pub. Health Law § 2981(1)(b) 11

N.Y. Pub. Health Law § 2982(2) 8, 11

Other Authorities

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Helga Kuhse, *The Case for Active Voluntary Euthanasia*, 14 Law, Med. & Health Care 145 (1986) 19

Betty Rollin, *Last Wish* (1985) 18

IN THE

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DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York, and ROBERT M. MORGENTHAU, District Attorney of New York County,

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

STATEMENT OF THE CASE

This case challenges New York's statutes prohibiting assisted suicide as violative of the Fourteenth Amendment's guarantees of equal protection and liberty. Respondents assert that mentally competent, terminally ill adults have a protected liberty interest in choosing to hasten death in a certain, humane and dignified manner. This right necessarily entails medical assistance. Further, respondents allege that the challenged New York laws, which prohibit physicians from

prescribing medications that can be self-administered by mentally competent, terminally ill citizens of New York who wish to hasten impending death, but permit physicians to assist New York citizens in their choice to hasten death if they are dependent upon life support, violate the Equal Protection Clause of the Fourteenth Amendment.

FACTUAL BACKGROUND

I. RESPONDENT DOCTORS AND THEIR PATIENTS

Respondents Quill, Klagsbrun, and Grossman are New York doctors who regularly care for terminally ill patients. Each of these doctors encounters cases in which his professional responsibilities dictate that he honor competent, terminally ill patients' requests for prescription medication to hasten death:

> It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational, and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death when palliative care becomes ineffective or unacceptable if the patient so chooses.

JA 39 (Declaration of Dr. Quill); *accord* JA 59 (Dr. Klagsbrun); JA 73 (Dr. Grossman).

Each of these doctors has refused to honor such requests for fear of criminal prosecution under sections 125.15(3) and 120.30 of the New York Penal Law. These sections criminalize the assistance of a physician in committing or attempting suicide, although neither suicide nor attempted suicide is criminalized, and the term "suicide" is not defined. Dr. Quill

was investigated by a New York grand jury for one instance where he did render assistance. JA 39-42.

The original plaintiffs included three individuals then in the final stages of terminal illness: Jane Doe, George A. Kingsley, and William A. Barth. Ms. Doe was a 76-year-old retired physical education instructor who was being strangled to death by a large cancerous tumor that had wrapped around her right carotid artery and was slowly collapsing her esophagus. JA 12, 93-95. Mr. Kingsley was a 48-year-old publishing executive suffering from a number of AIDS-related diseases, including cryptosporidiosis (a parasitic infection causing severe fevers and diarrhea), cytomegalovirus retinitis (a virus that attacks the retina and causes blindness), and toxoplasmosis (a parasitic infection causing lesions on the brain). JA 12, 86-88. Mr. Barth was a 28-year-old former fashion editor suffering from several AIDS-related diseases, including Kaposi's sarcoma skin lesions, cytomegalovirus of the stomach and colon, microsporidiosis, AIDS-related pneumonia, and cryptosporidiosis. JA 13, 82-84.

Ms. Doe, Mr. Kingsley, and Mr. Barth — mentally competent adults in the final stages of terminal illness — sought to alleviate their suffering and hasten death by self-administering drugs prescribed by their physicians. JA 12-13, 84-85, 88-90, 96-97. They died before the district court issued its ruling. Petition for Writ of Certiorari at 3 n.1.

Respondents continue to assert the constitutional claims of their other terminally ill patients. JA 15-17, 141-43, 154-56. *See Doe v. Bolton*, 410 U.S. 179, 187-89 (1973).

II. THE ASSISTANCE SOUGHT BELOW VS. THE ASSISTANCE NEW YORK PERMITS

Dr. Quill has substantial experience assisting patients to die through disconnection of life support and infusion with

medications, a means of hastening death explicitly authorized by New York law. These authorized practices are indistinguishable from the class of physician-assisted suicides prohibited by New York's penal statute. JA 104, 107-08, 116. First, both begin with careful clinical assessment of the patient's prognosis, mental competence and treatment alternatives:

> The removal of a life support system that directly results in the patient's death requires the direct involvement by the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment.
>
> * * *
>
> Once [the patients] are fully informed of their alternatives, and are sure they want the respirator removed even if it will result in their death, they then have the right to have treatment discontinued.

JA 104-05. Doctors are able to determine whether a patient's request to hasten death is rational and competent, or instead is motivated by depression or other mental illness or insanity, and New York practitioners currently make these determinations with respect to orders not to resuscitate and refusal of life-sustaining treatment. JA 114, 116.

Second, like legally prescribed methods, legally proscribed methods require affirmative steps by the patient's doctor:

> At a practical level, *the doctor must take several actions* to carry out the patient's desire. The doctor must *turn off the breathing machine*, *disconnect the machine* from the tube that goes to the patient's lungs, and then *remove the tube* from the patient's lungs. These patients must be carefully monitored after the respirator is withdrawn.

JA 105 (emphasis added).

Third, both methods involve prescribing medication that hastens death. When a respirator is removed, "the doctor usually must also give morphine or barbiturates to ameliorate the patient's sensation of suffocation." *Id.* When hydration and nutrition devices are withdrawn, powerful sedatives are administered. JA 106. Under either circumstance, the medications can and do contribute to death.

> These medications [morphine and barbiturates] must often be used in doses that contribute to the patient's death by suppressing their respiratory drive.

JA 105. *See* JA 106 (patients treated "with sedatives that hasten the patient's death").

III. THE LOWER COURTS' DECISIONS

Respondents concur in the third and fourth paragraphs of petitioners' Statement of the Case, describing the rulings below.

REASONS FOR DENYING THE PETITION

I. THERE IS NO CONFLICT AMONG THE LOWER COURTS

A. There Is No Conflict Between Federal Circuits

The Second Circuit unanimously ruled that New York's law prohibiting assisted suicide violates the Equal Protection Clause because it "does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths," and distinctions made with respect to such persons "do not further any legitimate state purpose." *Quill v. Vacco*, 80 F.3d 716, 727 (2d Cir. 1996).

The reasoning of the Ninth Circuit, the only other federal appellate court to consider the matter, is squarely consistent with that of the Second Circuit. The Ninth Circuit concluded that there is no "ethical or constitutionally cognizable" basis upon which to distinguish between physician assistance in hastening death by the act of prescribing medications for that purpose and the act of withdrawing or withholding life support. *Compassion In Dying v. Washington*, 79 F.3d 790, 821-24 (9th Cir. 1996) (en banc). Thus, there is no conflict among the federal appellate courts that have considered the issue of physician assistance in dying.

Recognizing this, petitioners instead assert that the Second Circuit decision is "fundamentally at odds" with that of the Ninth Circuit. Petition for Writ of Certiorari at 15. The Second Circuit's reasoning is "at odds" with the Ninth Circuit's only insofar as the Second Circuit felt constrained to recognize previously unidentified liberty interests. *Quill*, 80 F.3d at 723-25. To the extent there is a conflict between the Second Circuit and the Ninth Circuit on the liberty claim, that is not the basis of petitioners' request for relief. Petitioners prevailed on that issue in the ruling they seek to bring before

this Court for review. Moreover, petitioners' statement of the Questions Presented makes clear that they seek review only of the equal protection analysis.

B. There Is No Conflict Between a Federal Court and a State Court of Last Resort

Petitioners' representation that a conflict exists between the Second Circuit decision and that of a state court of last resort also is inaccurate. The Michigan Supreme Court, which reviewed Michigan's statute prohibiting physician-assisted suicide, was presented only with a Fourteenth Amendment liberty claim, and its holding is limited to that claim. *People v. Kevorkian*, 527 N.W.2d 714, 724, 733 (Mich. 1994) ("We would hold that the Due Process Clause of the federal constitution does not encompass a fundamental right to commit suicide, with or without assistance, and regardless of whether the would-be assistant is a physician."), *cert. denied*, 115 S. Ct. 1795 (1995). The court's footnote reference to the Equal Protection Clause, cited by petitioners at page 15, comprises the Michigan Supreme Court's entire equal protection discussion and is dicta.[1]

Moreover, the Second Circuit's equal protection ruling is based upon a finding that the State of New York, in both statutory and common law, has disavowed an absolute commitment to preserving life. *Quill*, 80 F.3d at 727-29. Thus, the ruling is based on the particulars of New York's statutory and common law and cannot give rise to a conflict,

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[1] In tacit acknowledgment of the absence of any true conflict between the Second Circuit and the Michigan Supreme Court, petitioners cite to a Michigan state trial court decision in which petitioners claim the equal protection claim was "squarely and fully presented." Petition for Writ of Certiorari at 15 n.6. Even if correct, a trial court decision does not create a conflict worthy of this Court's attention. Supreme Court Rule 10.1(a).

even if the Michigan Supreme Court had been presented with an equal protection claim based upon Michigan statutory and common law. The Second Circuit decision turns entirely upon the law of New York and how that state has chosen to empower its citizens in making end-of-life decisions.

At the time the Michigan Supreme Court ruled, Michigan's statutory law was less protective of patient choice than that of New York. For instance, Michigan had not yet enacted a measure permitting the execution of a "do-not-resuscitate order." Even Michigan's 1996 law permitting such orders imposes more obstacles to patient choice than the analogous law in New York. *Compare* 1996 Mi. ALS 193; 1996 Mi. P.A. 193; 1995 Mi. SB 452 § 2(e) (requiring execution of order in writing and permitting compliance with a patient's order only "in a setting outside of a hospital, a nursing home, or a mental health facility") *with* N.Y. Pub. Health Law § 2964(2) (permitting consent to order orally during hospitalization, or in writing prior to or during hospitalization). Michigan's statute governing health care proxies is also more onerous than that of New York. *Compare* Mich. Comp. Laws § 700.496(9)(e) (requiring "clear and convincing" expression of patient's desire to forego life sustaining medical treatment) *with* N.Y. Pub. Health Law § 2982(2) (requiring only that patient's wishes regarding artificial nutrition and hydration be reasonably known or knowable). Thus, were an equal protection analysis conducted of Michigan's statute prohibiting assisted suicide, the conclusion might have been different than that reached by the Second Circuit with respect to New York's law.

Finally, the statute reviewed by the Michigan Supreme Court has expired by its own terms. Mich. Comp. Laws § 752.1027. Thus, even if the Michigan Supreme Court's ruling did present a conflict, that conflict has evaporated. This was recognized by the State of Michigan in its opposition to a petition for writ of certiorari. *Hobbins v. Michigan*, No. 94-

1473 (Oct. Term 1994), Brief for Respondent in Opposition at 13 ("The challenged statute no longer exists. In these circumstances, an order declaring its unconstitutionality and enjoining its enforcement would be meaningless.").

II. REVIEW BY THIS COURT AT THIS TIME IS PREMATURE

Issues surrounding patient choice and physician assistance in hastening death continue to be reviewed by lower courts. For example, respondents are aware that at least one case raising similar issues is pending. *McIver v. Krischer*, CL96-1504AF, Palm Beach Circuit Court, 15th Judicial Circuit, Florida. This suggests that this Court should defer considering these issues at this time.

Sound principles of judicial restraint also counsel against granting review at this time. *See, e.g., McCray v. New York*, 461 U.S. 961, 963 (1983) (certiorari denied where issue requires "further study" in lower courts "before it is addressed by this Court"); *Gilliard v. Mississippi*, 464 U.S. 867, 869 (1983) (Marshall, J., dissent from denial of certiorari to "those of my colleagues who agree with me that . . . these cases present important constitutional questions, but believe that this Court should postpone consideration of the issue until more state supreme courts and federal circuits have experimented with substantive and procedural solutions to the problem"); *California ex. rel. Cooper v. Mitchell Bros.' Santa Ana Theater*, 454 U.S. 90, 98 (1981) (Stevens, J., dissenting from grant of certiorari on grounds of traditional practice of avoiding premature adjudication of constitutional principles).[2]

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[2] Denial of review at this time, of course, would suggest no expression upon the merits of the case. *See, e.g., Maryland v. Baltimore Radio*

III. THE SECOND CIRCUIT CORRECTLY DECIDED THAT NEW YORK PENAL LAW SECTIONS 125.15(3) AND 120.30 DENY EQUAL PROTECTION

In addition to the lack of conflict and prematurity factors disfavoring review at this time, review is also unnecessary because the decision below is correct.

This petition is limited to challenging the application of the rational basis standard in an equal protection analysis of New York's laws governing end-of-life decisions.[3] New York law grants a high degree of patient autonomy over end-of-life decisions. For example, New York permits otherwise healthy people with life expectancies of many decades to refuse life-saving treatment and allows patients to delegate by proxy to others a decision to bring about their death by altering their medical treatment. The record here shows no rational basis for distinguishing the cases of mentally competent, terminally ill patients who seek to end their suffering through self-administered prescription drugs from all the other cases in which New York statutory and common law grants patient autonomy over end-of-life decisions. Petitioners' argument that the writing of a prescription constitutes "active" physician assistance as compared to the "passive" posture involved in withdrawing treatment, such as a respirator or feeding tube, is not supported by the record. In fact, the withdrawal of life support typically involves a whole course of treatment, sometimes lasting days or weeks, which includes the administration of medications, such as morphine, that

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Show, Inc., 338 U.S. 912, 919 (1950); *United States v. Carver*, 260 U.S. 482, 490 (1923).

[3] To the extent that the Second Circuit erred in its analysis, it was by utilizing the lowest standard of review, rather than the heightened standard of review appropriate given the existence of a protected liberty interest.

themselves hasten death. In these circumstances, the petition presents no question warranting this Court's review.

A. New York Law Grants Broad Patient Autonomy Over End-of-Life Decisions

New York's statutory and common law already expressly authorizes patients to make end-of-life decisions with physician assistance in circumstances far less compelling than those here.

New York statutes concerning orders not to resuscitate and health care proxies specifically permit patients to direct their physicians to assist them to die. The New York Public Health Law pertaining to orders not to resuscitate provides that a patient's attending physician must either issue the order or object and transfer the patient to another physician, or submit the matter to dispute mediation. N.Y. Pub. Health Law § 2964(2). The patient need not be terminally ill in order to request an order not to resuscitate. *Id.* §§ 2964(1), 2964(3). When a surrogate is making medical decisions for a patient lacking capacity, the surrogate may request an order not to resuscitate not only if the patient is terminally ill, but also if the patient is permanently unconscious, if resuscitation would be medically futile, or if "resuscitation would impose an extraordinary burden on the patient in light of the patient's medical condition and the expected outcome of resuscitation for the patient." *Id.* § 2965(3)(c)(iv). Section 2976 of the New York Public Health Law suggests that state courts may issue orders not to resuscitate even in circumstances other than those explicitly authorized by the statute.

Under provisions pertaining to health care proxies, a competent principal may appoint a health care agent to make medical decisions for the principal in the event of incapacity according to the "principal's wishes" or the "principal's best interests." *Id.* §§ 2981(1)(b), 2982(2). The agent may make

all decisions regarding life-sustaining treatment except those decisions concerning unascertained wishes regarding artificial hydration and nutrition. There is no requirement that an adult be terminally ill when the decision to request assistance to die is embodied in the proxy or implemented by the agent.

In addition to the rights granted in these statutes, New York common law grants broad rights of patient autonomy. The New York Court of Appeals, quoting Justice Cardozo's view that every human being "'of adult years and sound mind has a right to determine what shall be done with his own body,'" has held:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, *it is the individual who must have the final say* in respect to decisions regarding his medical treatment in order *to insure that the greatest possible protection is accorded his autonomy and freedom* from unwanted interference with the furtherance of his own desires.

Rivers v. Katz, 495 N.E.2d 337, 341 (N.Y. 1986) (recognizing the right of patients to refuse psychotropic medication) (emphasis added) (quoting *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914)).

The patients for whose benefit this action was brought are all:

(1) mentally competent

(2) terminally ill patients

(3) wishing to receive physician assistance through the prescription of drugs that

(4) the patients may choose

(5) to self-administer

(6) to hasten their own deaths.

An analysis of how New York has treated these characteristics in other contexts shows that there is no basis for distinguishing the patients herein from other New York citizens who are granted autonomy over end-of-life decisions.

1. Mental Competence

New York's Public Health Law affirmatively presumes that patients have the mental capacity to make end-of-life decisions. With respect to orders not to resuscitate, the Public Health Law provides that every adult "shall be presumed" to have capacity to make a decision regarding resuscitation. N.Y. Pub. Health Law § 2963(1). A patient has capacity so long as he or she has

> the ability to understand and appreciate the nature and consequences of an order not to resuscitate, including the benefits and disadvantages of such an order, and to reach an informed decision regarding the order.

Id. § 2961(3). Similarly, an adult "shall be presumed competent" to make a health care proxy. *Id.* § 2980(3).

Petitioners seek to justify the Penal Law subsections at issue here by presuming that terminally ill patients are depressed or vulnerable. This is an impermissible presumption under equal protection analysis. New York otherwise erects very high barriers to the determination that patients are anything other than fully competent. The statutes pertaining to orders not to resuscitate do not permit a presumption of lack of capacity. *See id.* § 2963(1). Indeed, while one physician is required to confirm that an adult has capacity to consent to an

order, two physicians must concur in a determination that an adult lacks capacity. *Id.* § 2963(3)(a).

The claim that respondents' patients are any more subject to pressure from "uncaring relatives" or physicians "with their own agendas" than the patients empowered by the statutes governing orders not to resuscitate and health care proxies has no support in the record; the disparity in protections afforded these two categories of patients is insupportable under the Equal Protection Clause.

In light of current New York law that presumes patient capacity to make end-of-life decisions, the Second Circuit correctly concluded that the State has no rational basis to presume that the mentally competent patients in question here lack capacity to make end-of-life decisions.

2. Terminal Illness

Petitioners' argument that the Second Circuit left unanswered "the question of whether 'terminal illness' is always readily and accurately identifiable and precisely when, and by what definition a patient should be deemed terminally ill," Petition for Writ of Certiorari at 12, is nonsense given that New York has already defined "terminal condition" by statute.[4] Moreover, the Second Circuit recognized that "New York may define [terminal] illness with more particularity." *Quill*, 80 F.3d at 731.

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[4] The Public Health Law defines a "terminal condition" as "an illness or injury from which there is no recovery, and which reasonably can be expected to cause death within one year." N.Y. Pub. Health Law § 2961(23). Federal health insurance laws define the term similarly. *See, e.g.*, 42 U.S.C. 1395x(dd)(3)(A).

New York itself places the very real rights of patients above all abstract "state interests." The right to hasten death in New York extends even to individuals who may fully recuperate following treatment, a significantly less compelling circumstance than that in which respondents' patients find themselves. For instance, a patient in New York may consent to an invasive medical procedure, be capable of full and immediate recuperation, and still have the common law right to refuse routine treatment necessary for survival.[5]

3. Physician Assistance in the Form of Prescriptions

Under New York law, medical advice and prescriptions constitute medical services to which a mentally competent, adult patient may consent, and "the consent of *no other person* shall be necessary." N.Y. Pub. Health Law § 2504(1) (emphasis added). Patients in New York hospitals are protected as follows:

> Every patient's civil and religious liberties, including the right to independent personal decisions and *knowledge of available choices*, shall not be infringed and the facility *shall en-*

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[5] The New York Court of Appeals held in *Fosmire v. Nicoleau*, 551 N.E.2d 77, 80-81 (N.Y. 1990), that a competent adult's common law "right . . . to determine the course of his or her own medical treatment" included the right of a healthy young mother to decline blood transfusions following delivery of a child by cesarean section. *Accord Erickson v. Dilgard*, 252 N.Y.S.2d 705, 706 (N.Y. Sup. Ct. 1962) (competent, informed adult may refuse blood transfusion after amputation because he "has the final say . . . in a system of government which gives the greatest possible protection to the individual in the furtherance of his own desires"). Thus the law currently allows essentially healthy patients, with substantial life to preserve, the right to bleed to death under a physician's care.

courage and assist in the fullest possible exercise of these rights.

Id. § 2803-c(3)(a) (emphasis added). In addition, every patient has the right to receive full information about his or her medical condition and to private physician consultations and treatment. *Id.* §§ 2803-c(3)(b), 2803-c(3)(e).

Physicians already prescribe medications that "contribute to" or "hasten" the patient's death in the course of assisting patients disconnected from life support to die. JA 105-06. These physicians are protected both by statute and by the common law. Furthermore, physicians have the right to abstain from assistance under the current law, as they will in any end-of-life scenario.

4. Patient Choice

New York has already decided that the State's interests most appropriately lie with patient choice, and acknowledges that end-of-life decisions involve consideration of the patient's religious and moral beliefs and the patient's best interests. N.Y. Pub. Health Law §§ 2965(3)(a), 2973(1), 2976(1). *See id.* § 2803-c(3).

In addition, the State's courts have concluded that New York's common law "right of self determination" provides the foundation for a competent adult patient's right to control his or her medical treatment even if the effect is to hasten death. *Rivers*, 495 N.E.2d at 341 (N.Y. 1986); *Delio v. Westchester County Medical Ctr.*, 516 N.Y.S.2d 677, 691-93 (N.Y. App. Div. 1983).

There can be no dispute that the State has given the widest latitude to a patient's right to choose the course of his or her own treatment.

5. Self-Administration of Drugs

Disconnecting life support equipment and providing medication contributing to death is in no way distinguishable from the assistance sought here.

Removal of life support requires health care professionals to participate actively in and monitor the process of dying. As Dr. Quill described it, to carry out a patient's desire for removal of life support, the doctor must take "several actions." JA 105. He must (1) turn off the breathing machine, (2) disconnect the machine from the tube that goes to the patient's lungs, (3) remove the tube from the patient's lungs, (4) give morphine or barbiturates, sometimes in continuous infusions and "in doses that contribute to the patient's death," and (5) provide ongoing monitoring. JA 105-06. Physicians "actively and openly assist [patients] to die," and that active participation "often includ[es] medical interventions that contribute to an earlier death." JA 107. *See Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 296-97 (1990) (Scalia, J., concurring) (noting "irrelevance of action-inaction distinction").[6]

Petitioners' characterization of death by removal of life support as "natural" is belied by the reality of the process of dehydrating or suffocating to death over an excruciating period of days or weeks. The patient for whom removal of a respirator or feeding tube remains as the only option for a "natural" death has reached that point only after experiencing numerous profoundly unnatural treatments. *See* JA 115. *See* Howard Brody, *Assisted Death — A Compassionate*

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[6] Petitioners have not and cannot identify any controlling authority to the contrary. Other than Justice Scalia's view that there is no distinction between so-called "active" and "passive" assistance, this Court has not expressed its view on this issue.

Response to a Medical Failure, 327 New Eng. J. Med. 1384, 1385 (1992) (medical technology has "extended the patient's life and resulted in the complications that have brought the patient to the present state of suffering" and set them up "for what many consider an unacceptable way of dying"); *see generally* Betty Rollin, *Last Wish* (1985) (describing mother's death from cancer).

In *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 641 n.2 (Mass. 1986), the dissent described the result of a physician disconnecting a gastronomy tube through which the patient had received nutrition and hydration:

> Removal of the G tube would likely create various effects from the lack of hydration and nutrition, leading ultimately to death. Brophy's mouth would dry out and become caked or coated with thick material. His lips would become parched and cracked. His tongue would swell, and might crack. His eyes would recede back into their orbits and his cheeks would become hollow. The lining of his nose might crack and cause his nose to bleed. His skin would hang loose on his body and become dry and scaly. His urine would become highly concentrated, leading to burning of the bladder. The lining of his stomach would dry out and he would experience dry heaves and vomiting. His body temperature would become very high. His brain cells would dry out, causing convulsions. His respiratory tract would dry out, and the thick secretions that would result could plug his lungs and cause death. At some point within five days to three weeks his major organs, including his lungs, heart, and brain, would give out and he would die. *The [trial] judge found that death by dehydration is extremely painful and uncomfortable for a human being.* The judge could not rule out the possibility that Paul Brophy could experience pain in such a scenario. *Paul Brophy's attending physician described death by dehydration as cruel and violent.*

(Emphasis added) (Lynch, J., dissenting). *See* JA 106 (the process of dehydrating, starving, losing control of mental and physical capacities, experiencing organ failure, passing into unconsciousness and dying with the help of medical personnel may take seven to 10 days or more). Other forms of withholding treatment are no more "natural." *See* JA 105 ("Since respiratory failure can be one of the most excruciating and frightening deaths possible, the doctor must also give morphine or barbiturates to ameliorate the patient's sensation of suffocation."); Helga Kuhse, *The Case for Active Voluntary Euthanasia*, 14 Law, Med. & Health Care 145, 147 (1986) (respiratory death involves "conscious air hunger," "gasping, an increased breathing rate, a panicked feeling of inability to get air in or out;" in death from withholding of dialysis, the patient remains conscious and experiences nausea, vomiting of blood and convulsions).

The only difference between allowing a dying patient to take a lethal dose of medication to hasten impending death and removing equipment and infusing medication during a prolonged period before death ensues is that the former is more humane. JA 107.

6. Hastening One's Own Death

In *Cruzan*, this Court acknowledged that a patient may direct the removal of life support with the intent of "caus[ing] her death." 497 U.S. at 267-68, 278. Other courts similarly acknowledge that a state interest in the prevention of irrational self-destruction is not at issue in reviewing a

competent, rational decision to direct the removal of life support when death is imminent. *Superintendent of Belchertown State Sch. v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977).

The State of New York permits patients to choose to hasten death in such extensive circumstances as to leave no room for denying that choice to other mentally competent, terminally ill adults. In *Fosmire* the New York Court of Appeals determined that a young mother had a common law right to bleed to death by refusing blood transfusions, despite the fact that she had consented to a cesarean section.[7] 551 N.E.2d 77.

Moreover, New York draws a distinction between the State's interest in a private decision that injures the public and a private decision that affects only the person making the decision.

> The State has a well-recognized interest in protecting and preserving the lives of its citizens. . . . In these instances [of withdrawal of treatment], it has been noted, a distinction should be drawn between the State's interest in protecting the lives of its citizens from injuries by third parties, and injuries resulting from the individual's own actions. When the individual's conduct threatens injury to others, the State's interest is manifest and the State can generally be expected to intervene. But the State rarely

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[7] Certainly a physical condition that results from informed consent to surgery should be considered "self-inflicted" to a much greater extent than a terminal illness. Similarly, a patient suffering from a terminal illness does not "want to die" any more than, or even as much as, a woman who chooses to bleed to death because of religious convictions.

> acts to protect individuals from themselves, indicating that the State's interest is less substantial when there is little or no risk of direct injury to the public. This is consistent with the primary function of the State to preserve and promote liberty and the personal autonomy of the individual. In many if not most instances the State stays its hand and permits fully competent adults to engage in conduct or make personal decisions which pose risks to their lives or health.

Id. at 81 (citations omitted). After *Fosmire*, the State simply cannot justify a blanket prohibition of a private decision that "injures" only the person making the decision. Indeed, the option of a humane, hastened death confers a benefit, not an "injury," to patients making this profoundly personal choice.

B. The Challenged Laws Deny Equal Protection

The Equal Protection Clause prohibits the State of New York from treating similarly situated individuals differently. *Plyler v. Doe*, 457 U.S. 202, 216 (1982); *F.S. Royster Guano Co. v. Virginia*, 253 U.S. 412, 415 (1920). Classifications drawn by state law must be rationally related to a legitimate state interest. *Romer v. Evans*, 64 U.S.L.W. 4353, 4357, 1996 U.S. LEXIS 3245 at **25-26 (May 20, 1996) ("finding it impossible to credit" Colorado's assertion that a state constitutional amendment prohibiting preferential status for homosexuals protected the freedom of association and other liberties of landlords, employers and others with personal or religious objections to homosexuality, or that the amendment would conserve state resources for use in fighting discrimination against other groups); *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985) (city failed to provide rational reasons why facilities for the mentally retarded would warrant zoning treatment distinct from the

treatment afforded facilities inhabited by fraternities, sororities, and other multiple dwelling facilities).

Applying these principles, the Second Circuit correctly decided that New York Penal Law sections 125.15(3) and 120.30 violate the Equal Protection Clause because the distinction New York draws between competent, terminally ill patients whose treatment involves life-sustaining equipment and those whose treatment does not involve such equipment is not rationally related to any legitimate state interest.[8]

CONCLUSION

For these reasons, the Petition for Writ of Certiorari should be denied.

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[8] In addition, the decision below can be affirmed on the alternative constitutional basis argued below, namely, the Fourteenth Amendment's guarantee of liberty. *See, e.g., Granfinanciera, S.A. v. Nordberg*, 492 U.S. 33, 38-39 (1989); *Washington v. Yakima Indian Nation*, 439 U.S. 463, 476 n.20 (1979).

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IN THE

Supreme Court of the United States

OCTOBER TERM 1995

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY TO BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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13 pp

TABLE OF CONTENTS

PAGE

I — THE SECOND CIRCUIT'S UNPRECEDENTED CONCLUSION THAT ASSISTED SUICIDE AND REFUSAL OF LIFE-PROLONGING TREATMENT ARE CONSTITUTIONALLY INDISTINGUISHABLE WARRANTS DEFINITIVE EXAMINATION BY THIS COURT 2

II — THE DECISION BELOW CONFLICTS WITH A DECISION OF THE SUPREME COURT OF MICHIGAN 6

Conclusion 9

TABLE OF AUTHORITIES

Cases PAGE

Browning, In re, 568 So.2d 4 (Fla. 1990) 4

Cipollone v. Liggett Group, Inc., 505 U.S. 504 (1992) 5

Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir. 1995), *rev'd*, 79 F.3d 790 (9th Cir. 1996), *reh'g en banc denied*, 1996 WL 315922 (9th Cir. June 12, 1996) 5

Conroy, In re, 98 N.J. 321, 486 A.2d 1209 (1985) 4

DeGrella ex rel. Parrent v. Elston, 858 S.W.2d 698 (Ky. 1993) 6

Fosmire, Matter of v. Nicoleau, 75 N.Y.2d 218, 551 N.E.2d 77 (1980) 4

Gardner, In re, 534 A.2d 947 (Me. 1987) 4

People v. Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S.Ct. 1795 (1995) 6, 7, 8

People v. Privitera, 23 Cal.3d 697, 591 P.2d 919, *cert. denied*, 444 U.S. 949 (1979) 5

Plyler v. Doe, 457 U.S. 202 (1982) 3

P.V.W., In re, 424 So.2d 1015 (La. 1982) 6

Quinlan, In re, 70 N.J. 10, 355 A.2d 647, *cert denied*, 429 U.S. 922 (1976) 6

Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987) 4

Storar, Matter of, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981) 3

PAGE

Van Holden v. Chapman, 87 A.D.2d 66, 450 N.Y.S.2d 623 (4th Dep't 1982) 4

Washington v. Yakima Indian Nation, 439 U.S. 463 (1978) 6

Whalen v. Roe, 429 U.S. 589 (1977) 5

New York Statutes

Education Law § 6530(3) (McKinney Supp. 1994) 5

Public Health Law § 2989(3) (McKinney 1993) 4

Other

New York State Task Force on Life and the Law, *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* (April 1986) 4

IN THE

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OCTOBER TERM, 1995

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DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY TO BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

I

THE SECOND CIRCUIT'S UNPRECEDENTED CONCLUSION THAT ASSISTED SUICIDE AND REFUSAL OF LIFE-PROLONGING TREATMENT ARE CONSTITUTIONALLY INDISTINGUISHABLE WARRANTS DEFINITIVE EXAMINATION BY THIS COURT

The central strategy of respondents' brief in opposition to the petition for certiorari is to conflate an analysis under the Due Process Clause with the elements of the asserted equal protection claim, and to hinge the whole on euphemistic language which seeks to obscure the essential differences between refusing life-prolonging medical treatment and committing suicide. Because, respondents argue, New York recognizes "broad patient autonomy," including in certain circumstances the so-called right to "hasten death," the State must be viewed as having "disavowed an absolute commitment to preserving life" (Opposition, p. 7) such that, as a matter of equal protection, the right to physician assisted suicide must accompany and coexist with the right to refuse life-prolonging medical treatment.

Unquestionably, the centerpiece of the Second Circuit's decision is its conclusion that there is no legal difference between the determination to refuse or withdraw artificial life support (an act which by no means suggests the refusal or withdrawal of further medical care), and the determination to seek a physician's assistance in killing oneself. Significantly, respondents do not challenge the historical overview of assisted suicide provided in the petition for certiorari (Petition, p. 6-9). That overview indicates that the conclusion of the court below is without merit, and that indeed, the Second Circuit has rewritten New York's law in the absence of any legitimate constitutional claim, something the federal courts may not do.

As respondents suggest, New York recognizes the common law right of a competent adult patient to decline medical treatment. *Matter of Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, *cert. denied*, 454 U.S. 858 (1981). However, this common law right cannot be characterized as one to "hasten death." To the contrary, in the very case that articulated the right, the New York Court of Appeals also stated that "[t]he State has a legitimate interest in protecting the lives of its citizens. . . . It may, by statute, prohibit them from engaging in specified activities, including medical procedures which are inherently hazardous to their lives." *Id.* at 377, 420 N.E.2d at 71. In *Matter of Eichner*, decided with *Storar*, the Court again stated:

> In other cases the State may be able to assert additional interests, such as, prevention of suicide or, perhaps, protection of minor children or dependents. Those concerns are inapplicable here. Brother Fox's condition [a permanent vegetative state] was not self-inflicted.

Id. at 377 n.6, 420 N.E.2d at 71 n.6.

The right to refuse medical treatment, the New York Court of Appeals has made clear, is not an overnight creation, but rather is the result of long-established common law principles. *Id.* at 376-77, 420 N.E.2d at 71. As demonstrated in the petition for certiorari (Petition, p. 6), the common law pedigree of the prohibition against assisted suicide is as well or better established, dating from colonial times. The simultaneous existence of the common law right and the common law prohibition indicates what common sense likewise suggests—that refusal of treatment and assisted suicide are not identical. They are, in this Court's terms, "things which are different in fact," *Plyler v. Doe*, 457 U.S. 202, 216 (1982), and that one is permitted does not mean, as a matter of constitutional law, that the other must be permitted as well.

The Second Circuit's failure to distinguish legally between refusal of treatment and assisted suicide, a failure now urged

upon this Court by respondents, is unprecedented, and indeed is in stark conflict with the conclusion reached by New York's highest state court as well as other state courts of last resort which have visited the issue. *See, e.g., Matter of Fosmire v. Nicoleau*, 75 N.Y.2d 218, 227, 551 N.E.2d 77, 82 (1980) ("merely declining medical care, even essential treatment, is not considered a suicidal act"); *In re Browning*, 568 So.2d 4, 14 (Fla. 1990) ("suicide is not an issue when . . . the discontinuation of life support 'in fact will merely result in . . . death, if at all, from natural causes' ") (citation omitted); *Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674, 685 (1987) ("[a]sserting the right to refuse medical treatment is not tantamount to committing suicide"); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987) (the "decision not to receive [medical] procedures, far from constituting suicide, is a choice to allow to take its course the natural dying process"); *In re Conroy*, 98 N.J. 321, 350-51, 486 A.2d 1209, 1224 (1985) ("declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide"). *Accord Van Holden v. Chapman*, 87 A.D.2d 66, 70, 450 N.Y.S.2d 623, 627 (4th Dep't 1982) ("[e]ven superficial comparison of the right to decline medical treatment with the right to take one's life illustrates their essential dissimilarity").[1]

[1] The Second Circuit's finding of no significant distinction between refusal or withdrawal of artificial life support and suicide is a clear departure from the thinking of New York's Legislature as well as its highest court. This is evidenced by, among other things, New York Public Health Law § 2989(3), which, as part of the statutory provision on health care agents and proxies adopted by the Legislature in 1990, unequivocally states: "This article is not intended to permit or promote suicide, assisted suicide, or euthanasia." N.Y. Pub. Health Law § 2989(3) (McKinney 1993). *See also* New York State Task Force on Life and the Law, *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law*, at v (April 1986) (indicating a presumption in favor of life in that "[t]he [DNR] legislation explicitly affirms the presumption under existing law that all patients in the event of cardiac or respiratory arrest consent to the provision of CPR").

In light of the foregoing, it is difficult to credit respondents' blithe assertion that review is "unnecessary because the decision below is correct" (Opposition, p. 10). The reasoning of the decision below is unprecedented, and whether or not this Court would view it as correct, it undoubtedly presents questions of fundamental importance, something which respondents at no point deny.[2]

It is equally difficult to credit respondents' perfunctory argument that "review by this Court at this time is premature" (Opposition, p. 9). The Second Circuit and the Ninth Circuit, constituting two of the most populous circuits in the nation, have each grappled with the issue of physician assisted suicide, the Ninth Circuit in three separate opinions. *See Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995) (reversing district court), *rev'd*, 79 F.3d 790 (9th Cir. 1996) (en banc) (reversing prior panel's decision and affirming district court), *reh'g en banc denied*, 1996 WL 315922 (9th Cir. June 12, 1996) (en banc) (rejecting sua sponte request of active judge for rehearing en banc).[3] A significant number of

[2] Nor can respondents successfully argue against a grant of review on the claimed basis that a physician's decision to prescribe lethal drugs to a terminally ill patient is a private matter in which the State has no right to intervene (Opposition, pp. 15-16, 20). State regulation of physician conduct is an essential feature of medical care. *See, e.g.*, N.Y. Educ. Law § 6530(3) (McKinney Supp. 1994) (authorizing discipline of physicians). In the context of the prescription and administration of powerful drugs, this Court has held that "the State has broad police powers in regulating the administration of drugs by the health professions," and has observed that "the State no doubt could prohibit entirely the use of particular Schedule II drugs." *Whalen v. Roe*, 429 U.S. 589, 603 & n.30 (1977) (upholding New York's triplicate prescription system for dispensing controlled substances). *See also People v. Privitera*, 23 Cal.3d 697, 705, 591 P.2d 919, 923 (concluding that "the state has the power to ban a drug with a recognized medical use because of its potential for abuse"), *cert. denied*, 444 U.S. 949 (1979).

[3] In this regard, it is noteworthy that the Ninth Circuit's analysis on this issue is fundamentally at odds with that of the Second Circuit. *See Cipollone v. Liggett Group, Inc.*, 505 U.S. 504, 508-09 & n. 2 (1992) (certiorari granted and dispute characterized as a "conflict" where numer-

state courts of last resort have addressed the legal distinction between suicide and withdrawal of life support. *See supra*. *See also People v. Kevorkian*, 447 Mich. 436, 482, 527 N.W.2d 714, 733 (1994), *cert. denied*, 115 S.Ct. 1795 (1995); *DeGrella ex rel. Parrent v. Elston*, 858 S.W.2d 698, 707 (Ky. 1993); *In re P.V.W.*, 424 So.2d 1015, 1022 (La. 1982); *In re Quinlan*, 70 N.J. 10, 43, 355 A.2d 647, 665, *cert. denied*, 429 U.S. 922 (1976). This is simply not a case where "further study" is warranted to avoid "premature adjudication of constitutional principles" (Opposition, p. 9). To the contrary, the life and death issues involved cry out for a definitive examination by this Court.

II

THE DECISION BELOW CONFLICTS WITH A DECISION OF THE SUPREME COURT OF MICHIGAN

As demonstrated in the petition for certiorari (Petition, pp. 14-15), the Second Circuit's decision conflicts with the decision of the Supreme Court of Michigan in *People v. Kevorkian*, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S.Ct. 1795 (1995). Nothing respondents offer in their brief (Opposition, pp. 7-9) vitiates this conflict. The Michigan Supreme Court's conclusion that the asserted equal protection right to assisted suicide cannot be derived from the acknowledged "right enjoyed by terminally ill persons who opt to forgo or discontinue life-sustaining medical treatment" because "the two situations are not the same for purposes of constitutional analysis," *id.* at 480 n. 57, 527 N.W.2d at 732 n. 57, is a holding rather than the dictum respondents claim it to be, and of course conflicts with the Second Circuit's opposite conclusion.[4] *See generally Washington v. Yakima Indian*

ous courts "agreed with [the] analysis of the Third Circuit, which differed from the analysis of the Supreme Court of New Jersey").

[4] Additionally, the suggestion that any conflict with the Michigan court's holding has "evaporated" with the expiration of the Michigan statute (Opposition, p. 8) ignores the very underpinnings of the Court's decision, which are independent of the statute itself, and which were applied equally to the common law challenges raised. Indeed, quoting Justice Jackson, Justice Boyle of the Michigan Supreme Court noted that "a judicial decision has a force of its own. 'The principle then lies about like a loaded weapon . . . . Every repetition imbeds that principle more deeply in our law' . . . ." *Kevorkian*, 447 Mich at 502, 527 N.W.2d at 742 (Boyle, J., concurring in part and dissenting in part). *See also id.* at 477, 527 N.W.2d at 730 (analyzing the constitutional issue in terms of "evolution of tradition" and "historical precepts").

Nation, 439 U.S. 463, 467-68 n.5 (1978) (review undertaken in a case in which the district court rejected the constitutional claims but the circuit court did not reach the question of whether the application of the challenged statute deprived it of equal protection of the laws).

Nor can respondents plausibly contend (Opposition, p. 8) that the *Kevorkian* decision depends on the fact that "[a]t the time the Michigan Supreme Court ruled, Michigan's statutory law was less protective" than that of New York, such that in Michigan there was no disparity between the treatment of those who sought to refuse care and those who sought assisted suicide. The *Kevorkian* decision itself establishes that respondents are incorrect on this point. In Michigan, as in New York, there is and was a right, rooted in the common law, to refuse or discontinue medical treatment. *See Kevorkian*, 447 Mich. at 466-474, 527 N.W.2d at 726-729. The equal protection analysis conducted by the Michigan court did not, as respondents suggest (Opposition, p. 8), turn on a careful examination of the "obstacles to patient choice" presented by the Michigan common law. Rather, the court simply acknowledged that there is a right to refuse or discontinue life-sustaining medical treatment and concluded, for both due process and equal protection purposes:

> that persons who opt to discontinue life-sustaining medical treatment are not, in effect, committing suicide. There is a difference between choosing a natural death summoned by an uninvited illness or calamity, and delib-

erately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying.

Id. at 472-73, 527 N.W.2d at 728-29.

The Michigan Supreme Court, in other words, squarely held that refusal of treatment and assisted suicide "are not the same for purposes of constitutional [equal protection] analysis." *Id.* at 480 n.57, 527 N.W.2d at 732 n.57. The court below held precisely the opposite. The conflict is inescapable and only this Court can resolve it.

CONCLUSION

FOR THE FOREGOING REASONS, THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE GRANTED.

Dated: Albany, New York
July 9, 1996

Respectfully submitted,

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No. 95-1858

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; NEW YORK CATHOLIC CONFERENCE; WASHINGTON STATE CATHOLIC CONFERENCE; OREGON CATHOLIC CONFERENCE; CALIFORNIA CATHOLIC CONFERENCE; MICHIGAN CATHOLIC CONFERENCE; CHRISTIAN LIFE COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; NATIONAL ASSOCIATION OF EVANGELICALS; THE LUTHERAN CHURCH-MISSOURI SYNOD; AND CHRISTIAN LEGAL SOCIETY IN SUPPORT OF PETITIONERS

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IN THE

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---

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE*

Pursuant to Rule 37.2 of the Rules of this Court, the United States Catholic Conference, New York Catholic Conference, Washington State Catholic Conference, Oregon Catholic Conference, California Catholic Conference, Michigan Catholic Conference, Christian Life Commission of the Southern Baptist Convention, National Association of Evangelicals, The Lutheran Church-Missouri Synod, and Christian Legal Society respectfully move for leave to file the accompanying brief *amici curiae* on behalf of the petitioners, Dennis C. Vacco, *et al.*, whose written consent has been provided to the Clerk of the Court. The respondents, Timothy Quill, *et al.*, refused to consent to the filing of this brief.

In support of its motion, these amici state:

1. The United States Catholic Conference is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Catholic Bishops in the United States. The Bishops of New York, Washington, Oregon, California, and Michigan are also members of the State Catholic Conferences of those respective states. The Conferences are vehicles through which the Bishops speak cooperatively and collegially on matters affecting the Catholic Church and its people. The Conferences advocate and promote the pastoral teaching of the Church on diverse issues, including the protection of human rights and the sanctity and dignity of human life. Each of the Conferences has been active in supporting state laws that protect persons from deadly self-inflicted harm. Roman Catholicism is the largest religious denomination in the United States, with over 60 million members in this country.

2. The Christian Life Commission is the moral concerns and public policy agency for the Southern Baptist Convention, the nation's largest Protestant denomination, with over 15.2 million members in over 38,000 autonomous local churches. The Commission is charged with addressing public policies affecting the sanctity of human life.

3. The National Association of Evangelicals ("NAE") is a nonprofit association of evangelical Christian denominations, churches, organizations, institutions and individuals. It includes some 42,500 churches from 75 denominations, and 300 parachurch ministries. NAE has joined in this and many other *amicus* briefs in the defense of human rights, including the right to life.

4. The Lutheran Church-Missouri Synod is the second-largest Lutheran denomination in the United States. It has about 6,000 member congregations and about 2.6 million individual members. In 1995, as a result of their deeply held religious beliefs on the sanctity of life, the congregations of the Synod passed a resolution expressing the Synod's objection "to medical personnel having any part in actively inducing death, even at the patient's request." The Synod resoived "to speak against any attempt to legalize physician-assisted suicide. . . ."

5. Founded in 1961, the Christian Legal Society ("CLS") is a nonprofit association of 4,700 Christian attorneys, law professors, and law students with chapters in every state and at 85 law schools. CLS's legal advocacy and information arm, the Center for Law and Religious Freedom, advocates for the protection of religious exercise and the sanctity of human life in federal and state courts nationwide.

6. This is a case of extraordinary national importance. The United States Court of Appeals for the Second Circuit below concluded that the Equal Protection Clause prevents New York from uniformly enforcing its criminal laws that prohibit intentionally aiding another to commit or attempt suicide. The finding that some class of citizens—in this case, the "terminally ill" in the "final stages" of their illness—are not protected under the homicide laws flies in the face of the very constitutional provision upon which the Second Circuit purported to ground its decision. This case involves not only a question of historic importance, but literally means life or death for some of the Nation's most vulnerable citizens. No issue could be more serious. No dispute could be more deserving of a full airing of all views.

7. The amici speak from religious traditions and recognize the dignity and sanctity of each human person. Because of this perspective, these traditions speak uniquely to a number of ethical, moral, and legal distinctions that are central to the outcome of this case, distinctions that were obscured by the court below. These traditions also speak powerfully about the Nation's proper role in caring compassionately for those afflicted with terminal illness.

WHEREFORE, the amici respectfully request that this Court grant their motion and permit them to file the accompanying brief *amici curiae* in support of the petitioners.

Respectfully submitted,

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June 14, 1996

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF AMICI	1
SUMMARY OF ARGUMENT	4
ARGUMENT	5
I. THE EQUAL PROTECTION CLAUSE DOES NOT REQUIRE UNEQUAL APPLICATION OF THE HOMICIDE LAWS	6
II. THERE IS A PROFOUND DISTINCTION BETWEEN WITHDRAWING MEDICAL TREATMENT AND ASSISTING IN A SUICIDE	8
III. THIS CASE RAISES FUNDAMENTAL QUESTIONS ABOUT THE ROLE AND RULE OF LAW IN THIS SOCIETY	13
CONCLUSION	16

TABLE OF AUTHORITIES

CASES: Page

Barber v. Superior Court, 195 Cal. Rptr. 484 (Cal. App. 1983) 9
Bartling v. Superior Court, 209 Cal. Rptr. 220 (Cal. App. 1984) 10
Brophy v. New England Sinai Hospital, 497 N.E.2d 626 (Mass. 1986) 10
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Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) 5, 8
Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990) 9, 12, 13
Donaldson v. Van de Kamp, 4 Cal. Rptr.2d 59 (Cal. App. 1992) 10
Furman v. Georgia, 408 U.S. 238 (1972) 8, 13
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Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995), *on appeal*, Nos. 95-35804, -35805, -35854, -35948, -35949 (9th Cir.) 6
Matter of Conroy, 486 A.2d 1209 (N.J. 1985) 10
Matter of Storar, 420 N.E.2d 64 (N.Y. App.), *cert. denied*, 454 U.S. 858 (1981) 9
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Moore v. City of East Cleveland, 431 U.S. 494 (1977) 7
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Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973) 14
People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995) 5
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Roe v. Wade, 410 U.S. 113 (1973) 13
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TABLE OF AUTHORITIES—Continued

CONSTITUTION & STATUTES: Page

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N.Y. Penal Law §§ 125.15, 120.30 6

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IN THE

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BRIEF *AMICI CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; NEW YORK CATHOLIC CONFERENCE; WASHINGTON STATE CATHOLIC CONFERENCE; OREGON CATHOLIC CONFERENCE; CALIFORNIA CATHOLIC CONFERENCE; MICHIGAN CATHOLIC CONFERENCE; CHRISTIAN LIFE COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; NATIONAL ASSOCIATION OF EVANGELICALS; THE LUTHERAN CHURCH-MISSOURI SYNOD; AND CHRISTIAN LEGAL SOCIETY IN SUPPORT OF PETITIONERS

INTEREST OF AMICI

The amici, representatives of various religious communities in the United States, unite here for the common

purpose of calling this Court's attention to a decision of singular moment in the development of constitutional law. The United States Court of Appeals for the Second Circuit ruled below that the Equal Protection Clause forbids a state to protect all persons, equally, from being assisted by others to inflict deadly harm upon themselves. No longer, the Second Circuit ruled, can our society uniformly prohibit one person from enabling another person to take his or her life. In reaching this shocking conclusion, the Second Circuit obliterated a distinction recognized for centuries in life, law, and morality: the distinction between letting nature take its course for a dying patient (which is everywhere permitted), and intervening in that course by intentionally providing a person with a lethal agent to cause death (which is a form of homicide in New York and most other states). Our laws have always condemned acts of deadly harm directed against others. The Second Circuit's extraordinary uprooting of this long-recognized proscription demands the attention of this Court, which is called upon to preserve a basic precept of American life and government—*that no one may take the life of another even if asked.*

Individual statements of interest follow.

The United States Catholic Conference is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Catholic Bishops in the United States. The Bishops of New York, Washington, Oregon, California, and Michigan are also members of the State Catholic Conferences of those respective states. The Conferences are vehicles through which the Bishops speak cooperatively and collegially on matters affecting the Catholic Church and its people. The Conferences advocate and promote the pastoral teaching of the Church on diverse issues, including the protection of human rights and the sanctity and dignity of human life. Each of the Conferences has been active in supporting state laws that protect persons from deadly self-inflicted harm. Roman Catholicism is the largest religious denomination in the United States, with over 60 million members in this country.

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Founded in 1961, the Christian Legal Society ("CLS") is a nonprofit association of 4,700 Christian attorneys, law professors, and law students with chapters in every state and at 85 law schools. CLS's legal advocacy and information arm, the Center for Law and Religious Freedom, advocates for the protection of religious exercise and the sanctity of human life in federal and state courts nationwide.

SUMMARY OF ARGUMENT

The petition for writ of certiorari seeks review of a decision that is as chilling as it is without foundation in law. The Second Circuit held below that New York homicide laws that prohibit intentionally aiding another to commit or attempt suicide may *not* be applied to everyone, equally, under the Equal Protection Clause. This extraordinary and unprecedented ruling—that "terminally ill persons" in the "final stages" of their illness, as a class, constitutionally must be *excluded* from the mandatory protection of these laws—ignores the very principle of equal protection upon which the court purported to ground its decision. The criminal law applies to *everyone*.

This case is not about withdrawing or refusing medical treatment so that nature may take its course. It is about providing the terminally ill with a death-producing agent for the express purpose of causing death. The Court of Appeals erroneously concluded that the Constitution forbids States to recognize a difference between the two. Thus, the Second Circuit cast aside as "irrational" a distinction that has achieved nearly universal recognition in the common law, statutory law, the medical profession, and countless court decisions. Indeed, in 1994, a Task Force appointed by the Governor of New York cited the distinction between declining medical treatment and administering a lethal agent with the intentional purpose of causing death, as one of many reasons for retaining the State's laws prohibiting assisted suicide.

The Second Circuit's decision, if uncorrected, will have deadly consequences for people who are already marginalized in our society. The poor, the elderly, members of minorities, and those without access to medical care—these are the ones who will be killed, the Task Force found, if the prohibition against assisted suicide is lifted. It is a grave injustice to rob any person of the protections against deadly harm that are extended to all others under the criminal law. Indeed, withholding such protections

is an injustice of unspeakable magnitude, for it leads to the literal destruction of the very lives that government is charged with protecting.

This case must be heard. The decision below must be reversed.

ARGUMENT

We seek the intervention of this Court to answer what without exaggeration, may be the most profound and far-reaching federal constitutional question ever to have demanded its attention. Although we Americans differ in many ways, each of us ultimately will face death, our own and that of loved ones. This case raises the question whether a centuries-old tradition—a tradition that dictates that *we will not take the life of another even if asked*—should be abandoned at the behest of a small, determined group of advocates who persist in claiming that our Constitution includes a right to obtain from another the means of committing an act of deadly, self-inflicted violence. So far these advocates have persuaded two courts—the court below [1] and the United States Court of Appeals for the Ninth Circuit [2]—to rule in their favor on distinctly different grounds.[3] Both decisions require action by this Court to correct the errors below.

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[1] *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

[2] *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (mandate stayed). We are informed that a petition for writ of certiorari is to be filed shortly.

[3] There is, in fact, a three-way conflict between *Quill* and other cases that have addressed the issue of assisted suicide. The Ninth Circuit in *Compassion in Dying* held that the "terminally ill" have a due process right to assisted suicide. 79 F.3d at 793-94, 838. The Second Circuit in *Quill* rejected an asserted due process right to assisted suicide, 80 F.3d at 723-25, but held that those in the "final stages" of a "terminal illness" have an equal protection right to assisted suicide. *Id.* at 731. Michigan's highest court held in *People v. Kevorkian*, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S. Ct. 1795 (1995), that there is neither a due process nor

Neither the text nor the history of the Constitution, nor any of this Court's decisions, embraces a "right to hasten death" requiring states to provide selective, status-dependent "exceptions" to general prohibitions against taking the life of another. That any court believes otherwise is sufficient reason to grant the pending petition for writ of certiorari. For sound legal, factual, and moral reasons, including the extraordinary and unprecedented breadth of the decision below, this Court must grant the petition and give this matter full consideration.

I. THE EQUAL PROTECTION CLAUSE DOES NOT REQUIRE UNEQUAL APPLICATION OF THE HOMICIDE LAWS

The New York homicide laws struck down in this case protect all persons, equally, from being aided and encouraged to inflict deadly harm upon themselves. N.Y. Penal Law § 125.15 (intentionally aiding another to commit suicide is a felony); N.Y. Penal Law § 120.30 (intentionally aiding another to attempt suicide is a felony). The Second Circuit concluded that the Equal Protection Clause prevents New York from applying sections 125.15 and 120.30 equally to all citizens. This startling conclusion—that the Equal Protection Clause actually requires radically unequal application of a criminal law depending on the health status of the intended victim—ignores the very principle of equal protection upon which the court purported to ground its decision. Clearly New York may uniformly enforce laws that prohibit one person from providing others with the means of taking their own lives. The opinion below challenges the fundamental principle that criminal laws, including those struck down in this case, are meant to protect everyone.

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equal protection right to assisted suicide. A federal district judge has held that an Oregon law excluding the terminally ill from criminal and civil protections against assisted suicide violates the Equal Protection Clause. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *on appeal*, Nos. 95-35804, -35805, -35854, -35948, -35949 (9th Cir.).

This Court should consider at the outset the dark import of the ruling below. The New York statutes at issue prevent what the law has always and everywhere allowed a state to prevent: conduct facilitating the direct taking of another person's life. This is not a case about withdrawing or refusing futile or unwanted medical treatment. This is a case about deliberately and intentionally giving people a lethal agent to make them die.

The court below reached its result because it presumed incorrectly the existence of a "right to hasten death." Having framed the issue in this fashion, it was an overly simplistic, albeit dramatic, leap for the court below to say, for equal protection purposes, that there is no distinction between causing someone to die from suicide and allowing someone to die by withdrawing life-saving medical treatment since both result in "hastening death." *Quill*, 80 F.3d at 729. Framing the issue in this fashion, however, obliterates a crucial distinction that the law and medical practice have always recognized. As this Court has made plain in its due process jurisprudence, the framing of the issue and the description of the asserted right are of extreme importance in deciding a case.[4] By presuming that there exists a "right to hasten death," without analysis and without taking into account any of the analytical steps prescribed by this Court for identifying non-textual rights,[5] the court below created the very legal error which requires the intervention of this Court now.[6]

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[4] *Planned Parenthood v. Casey*, 505 U.S. 833, 847-48 (1992); *Michael H. v. Gerald D.*, 491 U.S. 110, 118-30 (1989).

[5] Constitutional protection is accorded to those non-textual interests "deeply rooted in this Nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), or which are "implicit" in the very "concept of ordered liberty." *Palko v. Connecticut*, 302 U.S. 319, 325-28 (1937).

[6] There is no "right to hasten death." Intentionally hastening death is a homicide even if the victim would have died soon from some other cause.

Constitutional rights, moreover, are defined by their application and factual context. Decisions of this Court prove time and again

Far from promoting equal protection of the law, the decision of the Second Circuit represents a direct attack on the fundamental equality and dignity of each and every human life, including "terminally ill" persons in the "final stages" of their illness,[7] whom the Second Circuit singled out for disparate treatment.

Ours has always been a society that "strongly affirms the sanctity of life." *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan, J., concurring). The Fourteenth Amendment guarantees this fundamental value by requiring equal protection of the criminal law and by denying states the power to "deprive any person of life . . . without due process of law." To hold that the Constitution gives one class of persons a special "right" to enlist others in obtaining a lethal agent to end their own lives represents a judgment that some lives are no longer worth protecting. Any branch of government that would adjudge some lives no longer worth protecting threatens human life and liberty.

II. THERE IS A PROFOUND DISTINCTION BETWEEN WITHDRAWING MEDICAL TREATMENT AND ASSISTING IN A SUICIDE

The Second Circuit's inherently contradictory conclusion that the Equal Protection Clause forbids New York to protect all New York citizens against deadly self-

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that interests for which constitutional protection is sought "cannot be described merely at the level of philosophic abstraction. . . ." Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still A Wonderful Life?*, 70 Notre Dame L. Rev. 519, 559 (1995). There is a "right to marry," for example, but no right to marry one's blood relatives. There is a "right to direct the upbringing of one's children," but no right to expose them to deadly harm.

[7] In its opinion, the Second Circuit provided no definition of either "terminally ill" or "final stages," claiming that these are well understood. Yet, as the Ninth Circuit noted in *Compassion in Dying v. Washington*, there are 41 state laws providing widely different definitions of "terminal" illness. 79 F.3d at 818 & n.77.

inflicted harm might have been avoided had that court not obliterated a distinction that has been recognized for centuries in life, law, and morality. It is the distinction between letting nature take its course, on the one hand, and intervening in that course, on the other hand, by intentionally administering a lethal agent to cause the death of another person.[8] Indeed, the claim that there is no constitutionally permissible distinction between refusing medical treatment and deliberate killing ignores the very distinction upon which the right to refuse medical treatment was grounded in the first instance. *Matter of Quinlan*, 355 A.2d 647, 665 (N.J. 1976) ("We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support . . . in the face of irreversible, painful and certain imminent death"), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976).[9] Cases adhering to this crucial distinction are legion.[10] The distinction is also

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[8] The Second Circuit, while seeing no constitutionally relevant distinction between refusing medical treatment and assisted suicide, purported to limit the right to assisted suicide to the terminally ill. The right to refuse medical treatment, however, is not limited to the terminally ill. *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 269 (1990).

[9] Even the common law origin of the right to refuse unwanted medical treatment illustrates how radically different it is from an affirmative act of homicide or suicide. The right to refuse medical treatment is rooted in the common law right to be free of unwanted bodily contact. *Cruzan*, 497 U.S. at 269. From a physician's standpoint, the patient's "right" to decline treatment is a *limitation* on the doctor's power. Indeed, a doctor commits a battery if he or she treats a patient without the patient's consent. The common law, by contrast, has never granted a physician the power deliberately to cause death.

[10] *See, e.g., Matter of Storar*, 420 N.E.2d 64, 71 n.6 (N.Y. App.) (distinguishing a natural death from self-inflicted killing), *cert. denied*, 454 U.S. 858 (1981); *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Cal. App. 1983) ("Euthanasia, of course, is neither justifiable nor excusable in California"); *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (distin-

recognized in state living will statutes.[11]

Decisions to refuse treatment are "legally and ethically distinct" from decisions to administer "a lethal agent with the intentional purpose of terminating life." American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues L. & Med. 117, 118 (Summer 1992). Assisted suicide "involves not letting the patient die, but making the patient die. . . ." Stephen L. Carter, *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion* 236 (1993). The American Medical Association recognizes a "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment." AMA Council on Ethical and Judi-

guishing a "competent, rational decision to refuse treatment when death is inevitable" from an act of intentional self-destruction; *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225-26 (Cal. App. 1984) (suicide is distinguishable from death from natural causes which results from disconnecting a respirator from a comatose, terminally ill patient); *Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (declining life-sustaining medical treatment is distinguishable from suicide because it "merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury"); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. App. 1986) (a "decision to allow nature to take its course is not equivalent to an election to commit suicide with . . . parties aiding and abetting therein"); *Brophy v. New England Sinai Hospital*, 497 N.E.2d 626, 635 n.29, 638 (Mass. 1986) ("the law does not permit suicide," which is distinguishable from the decision to remove life-sustaining treatment from a patient who is in a persistent vegetative state and unlikely to regain cognitive functioning); *Donaldson v. Van de Kamp*, 4 Cal.Rptr.2d 59, 63 (Cal. App. 1992) ("Here there are no life-prolonging measures to be discontinued. Instead, a third person will simply kill [the plaintiff]"). *See also* Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Oregon L. Rev. 449, 465-66 n.59 (1995) (citing additional cases).

[11] Alan D. Lieberson, *Advance Medical Directives* 93, 317-18 (1992).

cial Affairs, *Report 1-93-8*, at 2.[12] To restate the AMA position:

> When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

Id. Elimination of this distinction by the court below overrides the medical profession's own "unqualified opposition to physician-assisted suicide." Brian McCormick, *Continued Opposition: House Refuses to Open Door on Physician-Assisted Suicide*, Am. Med. News, Dec. 20, 1993, at 7. In simple terms, in the case of termination of medical treatment, it is the underlying pathology that prevails—the inability to breathe or eat or swallow. In a "suicide," it is the administration of a lethal agent that deliberately disrupts that course. Because so much of the common law is based on issues of intent, ignoring such distinctions, as the court did below, fundamentally alters this most basic protection and puts at risk every life at one of its most vulnerable stages.

Like the AMA, ABA, and countless courts, New York knows (and argued below) that there is a material difference between terminating medical treatment and assisting

[12] Individual health care professionals understand the difference as well, with 87% of physicians and nurses in a recent study agreeing that "to allow patients to die by forgoing or stopping treatment is ethically different from assisting in their suicide." Mildred Z. Solomon, *et al.*, *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. of Pub. Health 14, 17-18 (Jan. 1993).

in a suicide. In 1994, the 25-member Task Force on Life and the Law appointed by the Governor of New York concluded that the distinction was one of many reasons for retaining the existing New York ban on assisted suicide. The Task Force wrote:

> As . . . courts have recognized, the fact that the refusal of treatment and suicide may both lead to death does not mean that they implicate identical constitutional concerns. The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity. . . . It is this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment. Restrictions on suicide, by contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.

New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 71 (1994).

Contrary to the Second Circuit's opinion, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), does not dictate a different result. In *Cruzan*, this Court held that a state may require clear and convincing evidence of a comatose patient's wishes before allowing discontinuation of artificially provided nutrition and hydration at the direction of a surrogate. This Court, in *Cruzan*, never endorsed the administration of a lethal agent under the guise of a right intentionally to "hasten death." Rather, *Cruzan* (a) involved the discontinuance of an allegedly intrusive and burdensome medical treatment, (b) upheld the State's interest in preserving the patient's life (regardless of its alleged "quality") as against the wishes of those who sought to discontinue

treatment,[13] and (c) protected the exercise of the right against a possible erroneous determination by allowing a State to require particularly strong proof of the patient's wishes.

III. THIS CASE RAISES FUNDAMENTAL QUESTIONS ABOUT THE ROLE AND RULE OF LAW IN THIS SOCIETY

The purported right to have one person provide another with a lethal agent to take his or her own life is often described as a matter of personal autonomy—unlimited, exclusive self-determination. Such limitless autonomy threatens the way we order ourselves as a democratic society.

In this society, law has always been a guide and regulator. It is about *ordered* liberty. *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). The law has always acted to restrain personal choices that harm persons or the common good. Because we are a society that "strongly affirms the sanctity of life,"[14] we Americans have not endorsed demands to assist those who would make seemingly personal choices that diminish their own lives or the common good. For example, this Court has never held that the Constitution gives a person an absolute right to do with one's body as he or she pleases. *Roe v. Wade*, 410 U.S. 113, 154 (1973) (refusing to recognize such a right). Thus, a person has a right to refuse medical treatment, but no right to refuse vaccination from contagious diseases. *Jacobson v. Massachusetts*, 197 U.S. 11, 26-27 (1905) (rejecting autonomy right in favor of common good). "The state statute books are replete with constitutionally unchallenged laws against prostitution, suicide, voluntary self-mutilation, brutalizing 'bare fist' prize

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[13] States legitimately may assert "an unqualified interest in the preservation of human life. . . ." *Cruzan*, 497 U.S. at 282.

[14] *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan, J., concurring).

fights, and duels, although these crimes may only directly involve 'consenting adults.'" *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 n.15 (1973). The choice of a spouse is perhaps the deepest and most intimate of personal choices. Yet that choice too is limited by concerns for the common good, expressed in limitations based on affinity, consanguinity, and gender. In each of these instances, the claims of an individual are balanced against, and sometimes subordinated to, the common good.

For many reasons, the common good argues strongly against physician-assisted suicide. We need to ask—and this Court needs to confront—the larger consequences for education, economic reform, the eradication of poverty, discrimination, and other ills of society if we foster the attitude that, in the face of seemingly intractable difficulties, it is not only an individual's right to surrender but to enlist others to provide the means to end his or her life. It has been predicted that the poor, the elderly, minorities, and women [16] are more likely to be encouraged to "request aid" in dying (or have it requested "for" them by surrogates) than any other class. If pain and suffering are consequences of the failure of available medical care to respond fully to clinical depression or pain, then those most likely to suffer (and thus be tempted to choose suicide) are those for whom quality health care is the exception rather than the rule, or for whom adequate health care is altogether an illusion. The poor, the elderly, the isolated, minorities, the disabled, and women will disproportionally feel the impact of a social system that will now be built around a "right to hasten death." It was for this reason, among others, that the diverse members of the New York State Task Force on Life and the Law unanimously rejected the view that the

[16] Sidney Callahan, *A Feminist Case Against Self-Determined Dying in Assisted Suicide and Euthanasia*, 1 Studies in Pro Life Feminism 303-317 (Fall 1995).

State's prohibition against assisted suicide should be altered in any way:

> No matter how carefully any guidelines are framed, assisted suicide and euthanasia will be practiced through the prism of social inequality and bias that characterizes the delivery of services in all segments of our society, including health care. The practices will pose the greatest risks to those who are poor, elderly, members of a minority group, or without access to good medical care.

New York State Task Force on Life and the Law, *supra* at xiii.

This case asks plainly how constitutional law and constitutional principle can and should develop over the foreseeable future. It asks whether the rule of law, which traditionally has prevented people from enlisting others to carry out self-destructive impulses, may crumble in the face of some newly-minted claim of unbridled autonomy. It asks whether traditional and valued distinctions in the law and in medical practice must give way to these new claims of autonomy—claims which are self-contradictory, for they destroy the very person whose freedom they claim to maximize. At bottom, this case asks whether the kind of society we are to become will reflect our deepest values or none at all. Some argue that the time for euthanasia has arrived simply because our society lacks the will to stop it. On the contrary, these amici vigorously stand against it because it runs counter to our nature and the common good. Our society is made richer through the lives and well-being of all.

CONCLUSION

For the foregoing reasons of law and policy, this Court should grant the petition for certiorari filed by the Attorney General of the State of New York, Governor of New York, and District Attorney of New York County, and set this case for argument. The judgment of the Second Circuit should be reversed.

Respectfully submitted,

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June 14, 1996

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No. 95-1858

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October Term, 1995

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GEORGE E. PATAKI, Governor of the State of New York; and
ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBURN, M.D.;
and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

MOTION OF AGUDATH ISRAEL OF AMERICA FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF OF AMICUS CURIAE IN SUPPORT OF THE PETITION

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MOTION OF AGUDATH ISRAEL OF AMERICA FOR LEAVE TO FILE BRIEF AMICUS CURIAE

Pursuant to Rule 37 of the Rules of this Court, Agudath Israel of America respectfully moves for leave to file the accompanying brief *amicus curiae* in the above-captioned case.

Agudath Israel is a 74-year old national Orthodox Jewish movement with a deep and abiding interest in issues that touch upon the sanctity of human life -- and, therefore, on the moral tenor of our contemporary society. This case implicates some of the most profound issues of our time. As described more fully in the accompanying proposed brief, Agudath Israel views the decision below with deep

concern and believes that it deserves the Court's urgent attention.

Agudath Israel submits that it would bring to this case a perspective not currently before the Court. The accompanying proposed brief advances an argument not fully developed in the petition: the extent to which constitutionalizing a right to assisted suicide, particularly on equal protection grounds, is likely to have an extremely broad impact in a variety of contexts. In addition, as more fully discussed in the "Interest of the Amicus Curiae" section of the accompanying proposed brief, Agudath Israel approaches the issues raised by this case from its unique perspective of classical Jewish thinking.

Counsel for petitioners have consented, in writing, to Agudath Israel's filing a brief as *amicus curiae*. Counsel for respondents, however, has withheld such consent. Hence the need for this motion.

For the reasons stated above, Agudath Israel respectfully urges the Court to grant this motion for leave to file the accompanying brief *amicus curiae* in support of petitioners.

Respectfully submitted,

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TABLE OF CONTENTS

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

INTEREST OF THE AMICUS CURIAE 1

ARGUMENT: LEFT INTACT, THE DECISIONS OF THE COURT BELOW AND OF THE NINTH CIRCUIT IN *COMPASSION IN DYING* ARE LIKELY TO LEAD TO A BROAD EXPANSION OF THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA 4

Implications of the Ninth Circuit's Due Process Liberty Interest Analysis 6

Implications of the Second Circuit's Equal Protection Analysis. 8

CONCLUSION 14

TABLE OF AUTHORITIES

Cases **Page(s)**

Compassion in Dying v. *State of Washington*,
79 F.3d 790 (9th Cir. 1996) (en banc) . . . . . 5, *passim*

Compassion in Dying v. *State of Washington*,
49 F.3d 585 (9th Cir. 1995) 6

Cruzan v. *Director, Missouri Dept. of Health*,
497 U.S. 261 (1990) 8

Hooper v. *Bernalillo County Assessor*,
472 U.S. 612 (1985) 10

In re Storar, 52 N.Y. 363, *cert. denied*,
454 U.S. 858 (1981) 11

Matter of Westchester County Medical Center,
72 N.Y. 2d 517 (1988) 11

People v. *Kevorkian*, 447 Mich. 436 (1994),
cert. denied 115 S. Ct. 1795 (1995) 6

Quill v. *Vacco*, 80 F.3d 716 (2d Cir. 1996) . . . . . 5, *passim*

Schloendorf v. *Society of New York Hospital*,
211 N.Y. 125 (1914) 10

Statutes

N.Y. Public Health Law § 2982 (McKinney's 1993) 12

N.Y. Public Health Law § 2984 (McKinney's 1993) 12

Other Authorities

Bleich, *The Quinlan Case: A Jewish Perspective*,
Jewish Bioethics 266 (Heb. Pub. Co. 1979) 2

Jakobovits, *Regarding the Law Whether it is Permitted to Hasten the End of a Terminal Patient in Great Pain*,
31 *Ha-pardes* 29 (1956) 3

Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support be Discontinued?*, 145
Archives of Internal Medicine 130 (1985) 3

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INTEREST OF THE AMICUS CURIAE

Agudath Israel of America, a national grassroots Orthodox Jewish movement founded in 1922, is deeply concerned about the ruling below and the broader

implications it holds for the future, and joins petitioners in urging the Court to grant a writ of certiorari.

Informed by classical Jewish tradition which teaches that all human life is sacred, and possessed of the firm view that laws and judicial rulings that undermine the sanctity of human life send a message that is profoundly dangerous for all of society, Agudath Israel speaks out frequently, in a variety of legal policy settings, on a broad panoply of issues that arise at the onset and conclusion of the human life cycle. In this court, for example, Agudath Israel has submitted briefs as *amicus curiae* in the abortion rights cases of *Webster* v. *Reproductive Health Services* (decision reported at 492 U.S. 490 (1989)) and *Planned Parenthood* v. *Casey* (decision reported at 505 U.S. 833 (1992)); and -- more directly relevant to the issues involved in the instant case -- in the "right to die" case of *Cruzan* v. *Director, Missouri Department of Health* (decision reported at 497 U.S. 261 (1990)). Agudath Israel has also testified before the New York State legislature, as well as the New York State Task Force on Life and the Law, on the several statutes and statutory proposals discussed in the body of this brief, all of which are profoundly implicated by the decision below.

Agudath Israel's interest in the issue of physician assisted suicide is especially keen. It is a basic principle of Jewish law and ethics that "[m]an does not possess absolute title to his life or body." J.D. Bleich, *The Quinlan Case: A Jewish Perspective*, reprinted in *Jewish Bioethics* 266, 270 (Hebrew Publishing Co. 1979). Agudath Israel believes that recognition of that teaching, as expressed in the historical disapprobation of suicide and euthanasia, has served as one of the pillars of civilized societies throughout

the generations. That pillar is now in peril.

It is yet another principle of Jewish law and ethics that a doctor's role is to provide healing, not to hasten death. I. Jakobovits, *Regarding the Law Whether it is Permitted to Hasten the End of a Terminal Patient in Great Pain*, 31 *Ha-pardes* 29 (1956). Doctors who assist in the commission of suicide, even when motivated by the most humane of concerns, exceed the bounds of their own mandate and undermine public confidence in the medical profession. Agudath Israel views with considerable alarm the transformation of the physician's calling envisioned by the decision below.

Moreover, as representatives of a people whose numbers were decimated little more than half-a-century ago by a society that "progressed" from its "enlightened" practices of "mercy killing" to the mass slaughter of millions of human beings deemed physically or racially "inferior," Agudath Israel is particularly sensitive to the legal assignment of diminished levels of life protection based on diminished levels of life "quality". The dangers of such an assignment are well articulated by Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support be Discontinued?*, 145 Archives of Internal Medicine 130-31 (1985):

> "We have witnessed too much history to disregard how easily a society may disvalue the lives of the 'unproductive.' The 'angel of mercy' can become the fanatic, bringing the 'comfort' of death to some who do not clearly want it, then to others who 'would really be better off dead,' and finally, to

classes of 'undesirable persons,' which might include the terminally ill, the permanently unconscious, the severely senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps, the aged. . . . In the current environment, it may well prove convenient - and all too easy - to move from recognition of an individual's 'right to die' (to us, an unfortunate phrasing in the first instance) to a climate enforcing a 'duty to die.'"

ARGUMENT

LEFT INTACT, THE DECISIONS OF THE COURT BELOW AND OF THE NINTH CIRCUIT IN *COMPASSION IN DYING* ARE LIKELY TO LEAD TO A BROAD EXPANSION OF THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA

Earlier this year, within the space of one month, two federal circuit courts -- the Ninth Circuit in *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 (9th Cir., March 6, 1996) (en banc), and the Second Circuit in the decision below, *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir., April 2, 1996) -- found as-applied constitutional infirmities in Washington and New York state statutes that make it a crime to "aid" another individual in committing or attempting to commit suicide. The two rulings reached similar (though not identical) bottom lines, but arrived at their destinations through different constitutional routes.

The Ninth Circuit found a due process "liberty interest in choosing the time and manner of one's death," 79 F.3d at 798; and determined, in the context of "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors," that such due process liberty interest outweighed any countervailing interest asserted by the state. *Id.* at 838. The Second Circuit, in contrast, rejected the notion that there is any fundamental due process right to assisted suicide. 80 F.3d at 723-25. Instead, it relied on the equal protection clause in holding that physicians are constitutionally permitted to "prescribe drugs to be self-administered by mentally competent adults who seek to end their lives during the final stages of a terminal illness." *Id.*

at 718. Such persons, reasoned the court, are "similarly circumstanced" to final-stage terminally ill patients who enjoy the statutory and common law right to hasten their death by authorizing termination of life support, *id.* at 729; and, the court concluded, there is no legitimate state interest rationally served by distinguishing between the two categories. *Id.* at 730-31.

Both grounds of decision, Agudath Israel submits, are wrong. The better of the legal argument, we believe, is with the dissenting judges in the Ninth Circuit *en banc* decision (79 F.2d at 839 (Beezer, J.), 857 (Fernandez, J.) & 857 (Kleinfeld, J.)); with the Ninth Circuit's earlier panel opinion in *Compassion in Dying* v. *State of Washington,* 49 F.3d 585 (9th Cir. 1995); and with the Michigan Supreme Court in *People* v. *Kevorkian,* 447 Mich. 436 (1994), *cert. denied* 115 S. Ct. 1795 (1995).

Aside from being bad law, the rulings of the Ninth and Second Circuits are profoundly dangerous. Left intact, they are likely to lead to a broad expansion of the right to assisted suicide and euthanasia, far beyond the narrow confines of the particular contexts in which they arose. This is especially so, as demonstrated *infra*, with respect to the equal protection doctrine enunciated in the Second Circuit below.

Implications of the Ninth Circuit's Due Process Liberty Interest Analysis

The Ninth Circuit's *en banc* holding is itself broader than one might at first blush imagine: it encompasses, at least in Washington State, not only the decisions of persons who are terminally ill as that term is typically understood,

but also of persons who are in an irreversible coma or a persistent vegetative state, 79 F.3d at 831 & n.117; and also the decisions of duly appointed surrogate decision makers, *id.* at 832 n. 120. Moreover, as the court itself acknowledged, the logic of its due process analysis might well lead to active euthanasia for terminally ill patients:

> "We do not dispute the dissent's contention that the prescription of lethal medication by physicians for use by terminally ill patients who wish to die does not constitute a clear point of demarcation between permissible and impermissible medical conduct. We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them." 79 F.3d at 831 (footnote omitted).

Slippery though the Ninth Circuit slope may be, its incline is likely not to be quite so steep. For, as the court pointed out, the due process constitutional claim of a patient seeking suicide assistance will be determined, like all substantive due process claims, by weighing the strength of the various competing interests present in any given circumstance. The court's painstaking calibration of those competing interests led it to its bottom line determination: "The liberty interest at issue here...in the case of the terminally ill, is at its peak. Conversely, the state interests,

while equally important in the abstract, are for the most part at a low point here." 79 F.3d at 837. While Agudath Israel believes that the Ninth Circuit incorrectly undervalued the state's interest in preserving the life of even terminally ill persons -- "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life," *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 282 (1990) -- there is at least some basis to take comfort that the due process balancing framework will enable courts, in cases involving non-terminal patients, where the balance of competing interests tips in favor of the state, to draw the line: "So far down the slope, but no farther."

Implications of the Second Circuit's Equal Protection Analysis

The equal protection framework embraced by the Second Circuit, in contrast, would appear to include no such breaking mechanism. Once one accepts the court's conclusion that there is no meaningful distinction between assisted suicide and withholding or withdrawal of life-sustaining treatment, so that a patient who seeks termination of life support and a patient who seeks poison are "similarly circumstanced persons" who must be treated identically unless the state can demonstrate that treating them differently rationally advances a legitimate state interest, 80 F.3d at 729; and once one accepts the Second Circuit's additional conclusion that no such rational basis of distinction exists when the two persons are in the final stages of terminal illness, *id.* 730-31 -- there is no readily apparent logical way of drawing lines anywhere along the slope.

In concluding that the prohibition against assisted suicide, as applied to final-stage terminally ill patients, violates the equal protection clause, the Second Circuit posed a series of dramatic questions, and an equally dramatic answer:

> "But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes... And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life,' [citation omitted], when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: 'None.'" 80 F.3d at 729-30.

The questions are indeed dramatic, and so is the response -- but they are also highly misleading. For they imply that the equal protection analysis would be different in cases where the state's interest in preserving life would be stronger than the Second Circuit deems it to be at the final stages of terminal illness. In fact, however, it should make no equal protection difference whatsoever how far along the patient's terminal illness has progressed, or even whether he is terminally ill altogether.

The relevant equal protection inquiry here is *not* how strong the state's interest is in preserving life in any given

context, but whether treating "similarly circumstanced" persons differently -- in the Second Circuit's view, those who refuse life sustaining treatment and those who seek poison -- is rationally related to a legitimate state interest. As the Court stated in *Hooper* v. *Bernalillo County Assessor*, 472 U.S. 612 (1985): "When a state distributes benefits unequally, the distinctions it makes are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive that scrutiny if *the distinction* rationally furthers a legitimate state purpose." *Id.* at 618 (footnote omitted; emphasis added). If "[t]he ending of life by [withdrawal of life support] is nothing more nor less than assisted suicide," 80 F.3d. at 729, and if the disparate treatment cannot be constitutionally justified when the two similarly circumstanced individuals are in the final stages of terminal illness, it is difficult to see why the disparate treatment can be justified when the two similarly circumstanced individuals suffer from an entirely curable disease.

The implication of the Second Circuit's ruling, therefore, is that *wherever* the law permits an individual to forgo life support, equal protection demands that it also permit him to request a lethal prescription. That implication is nothing less than staggering, and merits this Court's careful scrutiny.

Consider the body of New York law implicated most directly by the ruling below. The right of competent persons to decline or discontinue life-sustaining medical intervention was first established at common law in *Schloendorf* v. *Society of New York Hospital*, 211 N.Y. 125, 129 (1914), where Judge Cardozo enunciated the basic doctrine of personal autonomy in medical decision-making:

"[E]very human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *In re Storar*, 52 N.Y. 363, 376-77, *cert. denied*, 454 U.S. 858 (1981), makes clear that the common law right of personal autonomy includes the right to refuse treatment necessary to preserve one's life. The New York courts have not limited such right to patients who are terminally ill -- certainly not to patients who are in the final stages of their terminal illness. Given the Second Circuit's rejection of any distinction between refusing life support and requesting poison, if a young patient with a good prognosis for recovery enjoys the common law right to refuse a life-saving operation, should he not also enjoy the right to a lethal prescription?

The same question will apply when a third party is legally authorized to make a decision on an incapacitated patient's behalf. Under New York common law, "the right to decline treatment is personal and...could not be exercised by a third party when the patient is unable to do so" unless there is "clear and convincing evidence" that the incapacitated patient would have refused life support. *Matter of Westchester County Medical Center*, 72 N.Y. 2d 517, 528-29 (1988). New York's legislature, however, has started moving away from the "clear and convincing evidence" standard. Most notably, in 1990, a statute was enacted empowering a duly designated health care agent to make virtually any life-and-death treatment decision on behalf of his incapacitated principal, irrespective of the principal's medical condition or prognosis. Such decisions are to be made on the basis of the principal's wishes; or, where the principal's wishes "are not reasonably known and

cannot with reasonable diligence be ascertained," on the basis of the principal's "best interests." N.Y. Public Health Law § 2982 (McKinney's 1993). And, currently pending in the state legislature is proposed new legislation developed by the New York State Task Force on Life and the Law, S. 5020 / A.6791, which would empower surrogates -- third parties appointed by the *law*, not by the *patient* -- to make decisions under certain medical circumstances to refuse life-sustaining treatment where the patient's "best interests" would be so served. The Second Circuit's equal protection analysis, it would seem, should empower such agents or third party surrogates to ask that the patient be provided with poison as well, so long as they deem it to be in the patient's "best interests."

There is yet one other noteworthy aspect of New York law: the legal obligation of an individual health care provider to carry out the instructions of patients and their duly appointed health care agents; or, if doing so would violate the provider's religious beliefs or sincerely held moral convictions, to cooperate in facilitating transfer of the patient to another medical practitioner who is prepared to carry out such wishes. N.Y. Public Health Law § 2984 (McKinney's 1993). If a doctor has religious beliefs or moral convictions that preclude him from helping the patient commit suicide, ought not equal protection require his cooperation in transferring the patient to a doctor who has no such qualms?

New York is not atypical in its recognition of a patient's right to decline life-sustaining interventions, either personally or through an agent or surrogate; if anything, New York's common law takes a harder line in insisting on clear and convincing evidence of an incapacitated patient's

wishes. See *Cruzan* v. *Director, Missouri Dept. of Health*, *supra*. If the Second Circuit's ruling is permitted to stand, its impact will be widespread, profound -- and, in our view, devastating.

CONCLUSION

The constitution can be a powerful engine of social change -- for better, and for worse. As Agudath Israel sees it, the Ninth Circuit's application of due process to the question of assisted suicide, and even more so the Second Circuit's application of equal protection, are examples of constitutionalism at its most dangerous.

For the reasons stated in the petition, and the additional reasons set forth herein, Agudath Israel of America respectfully urges the Court to grant a writ of certiorari and clarify the limits of constitutional moral revolution.

Respectfully submitted,

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No. 95-1858

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1995

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

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Respondents.

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Seven current and former Commissioners of the United States Commission on Civil Rights ("Civil Rights Commission") Carl A. Anderson, Robert P. George, Constance Horner, Russell G. Redenbaugh, William B. Allen, Esther Gonzalez-Arroyo Buckley, and Robert A. Destro ("Commissioners") hereby request, pursuant to Rules 21.2(b) and 37.2 of the Rules of this Court, leave to file the accompanying brief as

amici curiae in support of petitioners. These Commissioners are joined as *amici* by Evan J. Kemp, Jr., a former Chairman of the Equal Employment Opportunity Commission, who throughout his life and career has sought to defend the rights of handicapped people and ensure their full integration into society. *Amici* have obtained consent from petitioners' counsel to file this brief.[1] Counsel for respondents, however, refused to grant consent.

The Commissioners take this action in their individual capacities and not on behalf of the Civil Rights Commission itself. As a matter of policy, the Civil Rights Commission does not assume the role of *amicus curiae*. The named Commissioners, however, mindful of the historical achievements of the Commission, are motivated by their dedication to its ideals and believe that they can offer a useful perspective on the issues in this case.

Created as a part of the Civil Rights Act of 1957, the Civil Rights Commission has played a crucial -- and controversial -- role in our nation's efforts to assure equal protection before the law. *See* 42 U.S.C. § 1975c(2-3) (1983). From the beginning, its primary function has been to investigate facts and to make recommendations concerning the need to revise laws and regulations which deal with equal protection. *Id.* Since 1957, it has served as a bellwether, charting the direction of needed advances in civil rights and sounding the alarm when civil rights are threatened.

In keeping with its mandate, the Civil Rights Commission and its commissioners have individually and collectively braved great political and personal odds to bring attention to civil rights problems ignored or poorly understood by both courts and policy makers. The first commissioners were subjected to physical threats, and their confirmation hearings

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[1] Letters of consent from petitioners' counsel have been filed with the Clerk of the Court.

even included questions concerning payment of funeral expenses should they be killed in the line of duty. In the 1970s, the Civil Rights Commission conducted some of the earliest public debates over the concept of "structural racism" and the implications of that concept on the direction of civil rights enforcement policy. In the early 1980s, several *amici* were on the cutting edge of debates concerning the scope and direction of affirmative action programs of the sort this Court invalidated in *Adarand Constructors, Inc. v. Pena*, ___ U.S. ___, 115 S.Ct. 2097, (1995), and held extensive hearings designed to foster debate over programs which might be developed as acceptable substitutes.

The case at bar has grave implications for an issue which has long been of great concern, both to the Civil Rights Commission itself, and to *amici* -- medical discrimination against racial minorities and persons with disabilities. At the urging of several of the Commissioners, the Civil Rights Commission held extensive hearings on discrimination against persons with disabilities in our nation's health care system. *See* United States Commission on Civil Rights, *Medical Discrimination Against Children With Disabilities* (1989). At those hearings, assurances were given that effective safeguards existed to protect against violation of the rights of the subject patients. As the Civil Rights Commission's report shows only too well, however, the temptations to undervalue the right of those patients are strong, and the vaunted safeguards sadly inadequate.

In the case at bar, *amici* see cause for similar misgivings. In their judgment, the legal right to physician-assisted suicide recognized by the Second Circuit is misconceived, and they have no confidence that, once created, any safeguards can be crafted sufficient to restrain it. *Amici* are concerned that the decision of the Court of Appeals does not adequately consider the substantive threat to the lives of the poor, persons with disabilities, and racial minorities, and others who have historically suffered discrimination in the provision of health services.

Amici thus believe that they offer a strong and unique perspective on this case as *amici curiae* which will assist this Court in evaluating the opinion of the United States Court of Appeals for the Second Circuit in *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) and deciding whether to grant the requested writ of certiorari.

Respectfully submitted,

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Robert A. Destro and
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June 17, 1996

QUESTIONS PRESENTED

1. Should this Court grant certiorari to settle the question of whether, under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, a state retains a legitimate interest in prohibiting physician assisted suicide while allowing terminally ill, mentally competent patients to refuse artificial life support?
2. Should this Court grant certiorari to resolve a conflict between the United States Court of Appeals for the Second Circuit and a state court of last resort on the issue of whether the Equal Protection Clause prohibits the states from banning physician assisted suicide?

TABLE OF CONTENTS

PAGES

QUESTIONS PRESENTED v

TABLE OF AUTHORITIES viii

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 2

RESAONS FOR GRANTING THE PETITION 3

I. THE SECOND CIRCUIT'S EQUAL PROTECTION ANALYSIS FAILS TO RECOGNIZE SEVERAL RATIONAL BASES FOR NEW YORK'S DECISION TO PROHIBIT ASSISTED SUICIDE GENERALLY, INCLUDING PHYSICIAN-ASSISTED SUICIDE 3

a. The Second Circuit's Decision Does Not Adequately Consider the Threat Posed By Physician-Assisted Suicide to the Poor, Persons with Disabilities, and Racial Minorities Who Historically Have Suffered Discrimination in the Provision of Medical Services 3

b. The Second Circuit Has Created Dangerous Dual Roles for Physicians -- to Promote Life and Health on Some Occasions and to Act Deliberately to Bring About Death on Others 7

c. The Second Circuit Has Refused to Recognize New York's Right to Command the Broad Proscription of Conduct Which It Deems So Susceptible of Abuse as to Be Intolerable 9

II. THE SECOND CIRCUIT'S EQUAL PROTECTION ANALYSIS IS BASED ON A FAULTY LOGICAL EQUATION BETWEEN THE REFUSAL OF MEDICAL TREATMENT AND SUICIDE, HAS NO SOUND BASIS IN CONSTITUTIONAL PRECEDENT, AND UNWISELY ATTEMPTS TO REMOVE FROM DEBATE AND LEGISLATIVE RESOLUTION AN IMPORTANT AND CONTROVERSIAL PUBLIC POLICY ISSUE.....12

CONCLUSION.....17

TABLE OF AUTHORITIES

Cases **Page(s)**

Compassion in Dying v. Washington, 49 F.3d 586 (9th Cir. 1995) *rev'd* 79 F.3d 790 (1996) (en banc) 16

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 110 S.Ct. 2841 (1990) 16

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When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context (May 1994) 4

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Law and Theology in Judaism (2d Ser. 1976) 13

Select Committee on Medical Ethics of the House of Lords
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Other

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INTEREST OF *AMICI CURIAE*

Carl A. Anderson, Robert P. George, Constance Horner, Russell G. Redenbaugh, present Commissioners of the United States Commission on Civil Rights ("Civil Rights Commission"), William B. Allen, Esther Gonzalez-Arroyo Buckley, Robert A. Destro, former Commissioners of the Civil Rights

Commission, and Evan J. Kemp, Jr., former Chairman of the Equal Employment Opportunity Commission, respectfully submit this brief as *amici curiae* in support of petitioner. The interest of these individuals as *amici curiae* is fully set forth in the Motion for Leave File Brief as *Amici Curiae*, printed herewith *ante*.

SUMMARY OF ARGUMENT

Amici are deeply concerned about the implications of the newly-discovered right to physician-assisted suicide for the civil rights of the poor, persons with disabilities, and racial minorities. Based on their experience in striving to protect the civil rights of all Americans, *amici* find little comfort in the Second Circuit's express limitation of that right to competent, terminally ill adults or in its assurance that adequate safeguards can be crafted to prevent the abuse of that right. In their estimation, physician-assisted suicide, by its intrinsic nature and the reasoning offered in defense of its decriminalization, contains the seeds of both its expansion and its abuse. The Court of Appeals' decision should be reviewed by this Court and reversed because of that decision's fundamental illogic, its lack of sound constitutional or legal foundation, and its usurpation of a field of decision-making properly reserved to a state's citizens and their elected lawmakers. In addition, there is ample justification for New York's criminalization of all assisted suicide in the rational judgment that any exception to a thorough prohibition (such as an acceptance of physician-assisted suicide in certain instances) would pose an unacceptable risk to its citizens' lives, health, and access to uncompromised medical care -- a risk that can only be heightened in the case of the most vulnerable members of society.

REASONS FOR GRANTING THE PETITION

I. THE SECOND CIRCUIT'S EQUAL PROTECTION ANALYSIS FAILS TO RECOGNIZE SEVERAL RATIONAL BASES FOR NEW YORK'S DECISION TO PROHIBIT ASSISTED SUICIDE GENERALLY, INCLUDING PHYSICIAN-ASSISTED SUICIDE.

The Second Circuit recognized that, to pass muster under the applicable equal protection analysis, New York's law against assisted suicide (as applied to assistance from any source, including physicians) need only possess a rational basis. *Quill v. Vacco*, 80 F.3d 716, 725-727 (2d Cir. 1996). *Amici* suggest that, among the many rational justifications for New York's law, are (1) protecting its most vulnerable citizens, (2) preserving the integrity of the medical profession, and (3) guarding against the potential for abuse that would accompany any less sweeping prohibition.

a. The Second Circuit's Decision Does Not Adequately Consider the Threat Posed By Physician-Assisted Suicide to the Poor, Persons with Disabilities, and Racial Minorities Who Historically Have Suffered Discrimination in the Provision of Medical Services.

The Court of Appeals ignored as a rational basis for New York's law prohibiting assisted suicide, the State's desire to protect its most vulnerable citizens from the most extreme consequences of medical exploitation or neglect. To the contrary, the court's concern with such persons was not that their deaths might be encouraged or unduly facilitated by the medical establishment, but that they might not have sufficient access to the right to embrace suicide: "[W]ith respect to the protection of minorities, the poor and the non-mentally handicapped, it suffices to say that these classes of persons are entitled to treatment equal to that afforded to all those who now

may hasten death by means of life-support withdrawal". *Quill v. Vacco*, 80 F.3d 716, 730 (2d Cir. 1996). *Amici* respectfully submit that this conclusion reflects an inadequate awareness of the history of discrimination in the provision of medical services to the poor, persons with disabilities, and racial minorities. Moreover, *amici* suggest that the Court of Appeals' partial invalidation of New York Penal Law Sections 125.15(3) and 120.30 poses an unprecedented threat of exploitation in the delivery of health care.

In reviewing the specific issue of physician-assisted suicide, the New York State Task Force on Life and the Law ("New York State Task Force"), convened in 1985 by Governor Mario Cuomo, rejected the proposed repeal or amendment of the New York law on assisted suicide for precisely this reason. It's conclusion could not be any clearer or more deliberate:

> [I]t must be recognized that assisted suicide and euthanasia will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society including health care. Those who will be most vulnerable to abuse, error, or indifference are the poor, minorities, and those who are least educated and least empowered. This risk does not reflect a judgment that physicians are more prejudiced or influenced by race and class than the rest of society -- only that they are not exempt from the prejudices manifest in other areas of our collective life.
>
> While our society aspires to eradicate discrimination . . . we consistently fall short of our goal. The costs of this failure with assisted suicide and euthanasia would be extreme. Nor is there any reason to believe that the practices, whatever safeguards are erected, will be unaffected by the broader social and medical context in which they will be operating. This assumption is naive and unsupportable.

New York State Task Force on Life, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994).

Amici agree entirely with this conclusion of the New York State Task Force. Indeed, this conclusion is strikingly consistent with findings of the Civil Rights Commission itself in its multi-year study of discrimination in the provision of medical services to children born with severe disabilities. *See* United States Commission on Civil Rights, *Medical Discrimination Against Children with Disabilities* (1989). (For the convenience of the Court several copies of this report have been lodged with the Clerk.) The Civil Rights Commission found that "[a] significantly high incidence of medical discrimination against children with disabilities exists that is part of a much larger pattern of medical care discrimination against people with disabilities." *Id.* at 8. In addition, the Civil Rights Commission reported that:

> The grounds typically advanced to support denial of lifesaving medical treatment or food and fluids are based on erroneous judgments concerning the quality of life of a person with a disability or on social judgments that such a person's continued existence will impose an "unacceptable" burden on his or her family or on the Nation as a whole. These judgments are often grounded in misinformation, inaccurate stereotypes, and negative attitudes about people with disabilities.

Id. at 12. Although *amici* realize that certain circumstances of disabled patients denied medical services at the beginning of life may differ from circumstances pertaining to disabled, or other, patients facing life-and-death decisions at the end of life, nonetheless, like the New York Task Force, *amici* respectfully suggest that it is "naive and unsupportable" to suppose that decisions affecting physician-assisted suicide would not be subject to the same pressures and attitudes.

Amici assert that the context in which such decisions will be made cannot be separated from the historic reality of unequal health care and the health status of minorities in American society. In 1984, Secretary of Health and Human Services Margaret Heckler established a departmental Task Force on Black and Minority Health to conduct the first comprehensive review of national minority health issues compiled into one federal report. *See* United States Department of Health and Human Services, *Report of the Secretary's Task Force on Black and Minority Health* (August 1985). This report stated that:

> Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat, and cure disease, Blacks, Hispanics, Native Americans, and those of Asian/Pacific Islander heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology.

Id. at 1. The report continued that there has been "steady improvement in overall health status, while at the same time, persistent, significant health inequities exist for minority Americans." *Id.* at 2. What Secretary Heckler, in issuing this report, called this "tragic dilemma" remains with us still.

Perhaps it should be acknowledged, in light of the Second Circuit's inability to perceive any possible distinction between suicide and decisions of a patient to forego or discontinue life-supporting medical treatment, that, in the sphere of life support decisions, as well, the poor, persons with disabilites, and racial minorities face disparate treatment. That problem, too, entails issues of the deprivation of civil rights and needs to be addressed. But the persistence of serious risks in one sphere is a poor reason to strike down effective protections already existing in another sphere. Such an action makes as little sense as demolishing fire houses and police

stations in affluent suburbs, in the name of equal treatment, because there may be insufficient fire and police protection in the inner city.

Given the tragic vulnerability of the poor, persons with disabilites, and racial minorities to medical exploitation and neglect, the Second Circuit erred in failing to perceive the protection of these citizens as a rational basis for New York's decision to ban all assisted suicide.

b. The Second Circuit Has Created Dangerous Dual Roles for Physicians -- to Promote Life and Health on Some Occasions and to Act Deliberately to Bring About Death on Others

Our nation faces difficult choices today with regard to the provision of medical care. Many of those choices derive from the interplay between the high costs of various medical procedures and the limited resources which many patients can command. There are strong and disturbing tendencies to allow full compassionate care to gravitate toward dollars, insurance companies to court the healthy and avoid the sick, and persons with diminished physical or mental capacities to be considered imprudent destinations for the allocation of more than minimal medical resources.

The young, the old, the sick, persons with disabilites, the poor, and racial minorities are dependent now more than ever before on the high ethical standards of medical professionals. In the absence of such high standards, the physical and mental impairments experienced by such persons when they are in dire need of medical care (compounded by age-related inabilities to act aggressively in their own defense) are likely to subject them to the devaluation of their incommensurable worth as human beings. Doctors and nurses must be the champions of last resort of many who lack any other advocates.

The Second Circuit has now accepted the proposition that patients themselves can rationally conclude that their

physically or mentally diminished lives are no longer worth living and be entitled to a physician's assistance in committing suicide. If such conclusions are deemed rational when made by one person about himself, they cannot be considered any less rational when made about others. Whatever the medical factors may be that are deemed to justify suicide, they can be perceived by third parties and used to justify a decision for death, whether or not the patient may concur.

This poses a dreadful danger of infecting physicians' attitudes, in both subtle and less subtle ways. *Amici* see ample evidence of a pre-existing propensity in some doctors to be negatively influenced by various defects and disabilities in their treatment decisions, as reflected in the Civil Rights Commission's 1989 report *Medical Discrimination Against Children with Disabilities*, *supra*. Involving doctors both as accessories in acts of suicide and as evaluators of the rationality of patients' suicide decisions seems likely to exacerbate the danger of more doctors drifting away from a pure and strict allegiance to the ancient Hippocratic Oath. Instead, we are likely to see doctors becoming more inclined (as well-educated professionals prone to value highly their own judgments) to reach their own conclusions about which cases appropriately call for the exercise of their skill as healers and which for their unique legally conferred authority to grant final surcease. Even if there is no dramatic embrace of non-voluntary euthanasia, there is bound to be a dangerous tug in that direction as habits of mind and practice change.

In the judgment of *amici*, states are wholly justified in refusing to countenance anything which contributes to the dilution or contamination of a physician's single-minded devotion to fostering the life and health of his patients.

c. The Second Circuit Has Refused to Recognize New York's Right to Command the Broad Proscription of Conduct Which It Deems So Susceptible of Abuse as to Be Intolerable.

Amici believe that a state can rationally and legitimately conclude that some activities involve such serious harms and possess so great and unavoidable a potential for abuse that they should be prohibited absolutely. Thus, statutory rape laws certainly run counter to the fact that there may be individual cases where, say, a 14- or 15-year-old can and does grant knowing consent to sexual relations. *See e.g.*, Model Penal Code §§ 213.3(1)(a) and 213.4(6) (1974). But many states have decided that sexual abuse of minors is so harmful, and recognition of a limited sphere of permitted sexual relations with minors so susceptible of abuse, that they will prohibit such relations categorically.

Amici suggest that intentionally causing the death of a human being (including inciting or assisting a person to cause his own death) should be viewed in much the same way. The harm could not be greater (whether or not it is desired -- but then a desire in minors for sexual activity is not unheard of); and the potential for abuse is enormous. Even under a regime in which no opinion or authorization but a patient's own is given any weight, many pressures -- economic, professional, familial -- can be brought to bear to influence the patient's choice. Consider even the very slightest pressure imaginable. Why should any patient be made to feel that, by declining to embrace suicide during a terminal illness, he is behaving one whit more selfishly or less rationally than a supposedly more enlightened or ethically up-to-date patient?

But the panoply of pressures which can confidently be expected extends much further. The opinion of one's doctor, worry over financially or emotionally burdening one's loved ones, the pride of acting as rational and unsuperstitious persons are said to act, these are just a few of the pressures which are bound to infect and distort the system of logical and

autonomous decision-making that the Second Circuit envisions.

The situation will be even worse, of course, with the inevitable expansion of the "right" created by the Court of Appeals. Having concluded that it is inhumane to prohibit a competent and conscious adult patient facing a terminal illness from obtaining immediate release from pain and a diminished life, will the Second Circuit, or other courts, long insist that infant, incompetent, or unconscious patients be condemned to such suffering, simply because they are powerless to make the "rational" decision for themselves? Similarly, will the courts deny self-induced but assisted death to rational persons eager to embrace it, just because they are not terminally ill, or perhaps not even ill at all? And even before the courts act, will individual doctors, nurses, hospitals, parents, and spouses not be tempted (as some surely have been in the past, though without the greater encouragement and protection of a declared constitutional right to assisted suicide) to "push the envelope" of euthanasia, so to speak, in many ways.

The classic cautionary example of this downward progression can be found in the experience of the Netherlands. In the mid-1980s, Dutch courts created exceptions to criminal statutes prohibiting both assisted suicide and euthanasia to permit doctors to engage in both practices, though with the assurance that only consenting patients would "enjoy" these "rights." This regime of toleration of voluntary euthanasia then led fairly quickly to non-voluntary euthanasia, first de facto, and now more or less de jure. Incontrovertible evidence exists that, as a result of abuse by individual family members and physicians, many thousands of Dutch citizens have been killed without their consent. *See* John Keown, *Euthanasia in the Netherlands: Sliding Down the Slippery Slope? in Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (1995); John Keown, *Further Reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and the Van Der Maas Survey*, in *Euthanasia, Clinical Practice and*

the Law (Luke Gormally, ed., 1994). All too predictably, the victims of this downward progression have disproportionately been the most vulnerable members of Dutch society. American legislators who are concerned about protecting the rights of the poor, persons with disabilities, racial minorities, the very young and very old, the sick, the incompetent, and other "at risk" members of our society have ample reason to resist pressures to follow the Netherlands in taking that first step onto this treacherously slippery slope.

Amici, therefore, emphatically do not share the Second Circuit's view that "[i]t is difficult to see how the relief the plaintiffs seek would lead to the abuses found in the Netherlands." *Quill v. Vacco*, 80 F.3d at 730-731. It was exactly such relief that was the starting point in Holland. Under such circumstances, inevitably, it will be persons with disabilities who will be most at risk from the misguided compassion of their relatives and physicians. Their quality of life will be estimated, sadly but resignedly, and in many cases a decision made that a quality so limited cannot justify the prolongation of suffering. Assurances of strict safeguards notwithstanding, the ultimate destination of the trail blazed by the Second Circuit cannot be in doubt.

Moreover, even a passionate believer in the possibility of rigorous safeguards cannot deny that reliance on them entails serious risks. And with that modest recognition, *amici* suggest, there can be no justification for the Second Circuit's conclusion that a state cannot rationally decide to prohibit absolutely an activity with such grave inherent dangers and such high susceptibility of abuse.

II. THE SECOND CIRCUIT'S EQUAL PROTECTION ANALYSIS IS BASED ON A FAULTY LOGICAL EQUATION BETWEEN THE REFUSAL OF MEDICAL TREATMENT AND SUICIDE, HAS NO SOUND BASIS IN CONSTITUTIONAL PRECEDENT, AND UNWISELY ATTEMPTS TO REMOVE FROM DEBATE AND LEGISLATIVE RESOLUTION AN IMPORTANT AND CONTROVERSIAL PUBLIC POLICY ISSUE.

Amici believe that the special contribution which they can offer to the Court's consideration of this case derives from their experience and judgment in protecting the civil rights of all Americans, and especially of those most at risk for violation of their civil rights. In Part I of this brief, *amici* have attempted to present the arguments focused most directly on these concerns, which they feel they have a particular competence to make. Petitioners, and other *amici,* can ably analyze the serious flaws of logic and law and the lack of due regard for the legislative judgment of the people of New York which inform the Second Circuit's opinion. However, *amici* feel obliged to touch briefly on a few of these considerations insofar as they have important, if more indirect, implications for the adequate protection of civil rights.

The foundation of the Second Circuit's reasoning was that no valid distinction can be drawn between a terminally ill patient refusing to commence or continue life-supporting medical treatment and a terminally ill patient choosing to commit suicide. *Quill v. Vacco,* 80 F.3d at 729. The court did not demonstrate this as a conclusion as much as assert it as an incontrovertible proposition. Indeed, the Court of Appeals seemed to have prejudged this issue and to have selected a vocabulary consciously designed to obscure the differences between fundamentally unlike things. It created an artificial likeness between rejecting medical treatment and committing suicide by using the vague and misleading terminology that

each involves a decision to "hasten death." In more straightforward language, the former case entails a choice not to prolong life; the latter entails a choice to cause death.

For centuries, individual thinkers and whole societies have drawn crucial distinctions between all sorts of acts which result in the death of the actor -- from martyrdom in witness to cherished beliefs, heroism in battle, and risking deadly danger to save the lives of others, on the one hand, to the foolhardy commission of great risks for frivolous reasons and the deliberate embrace of death in suicide, on the other hand. Such thinkers and societies have had no trouble in seeing a profound difference between self-killing -- acting to achieve death as one's end and purpose -- and accepting either the inevitability or a high risk of death as a foreseeable consequence of acting to achieve some other end.

The Second Circuit's refusal to see any meaningful distinction between declining medical care and embracing suicide runs counter to the conclusions of unnumbered societies which have had no problem perceiving such a distinction and to a similar long tradition of philosophical reflection by thinkers embracing a wide array of philosophical and moral viewpoints. E.g., Germain Grisez and Joseph Boyle, *Life and Death with Liberty and Justice,* 407-422 (1979) (*see specifically,* Chapter 12, *Moral Responsibilities Toward Human Life,* including the analyses "Suicide and Causing One's Own Death," "Active Euthanasia: Voluntary and Non-Voluntary," "Omissions, Killing and Letting Die," and "Non-Treatment and Refusal of Treatment"); David Novak, *Law and Theology in Judaism,* 100ff (2d Ser. 1976); Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation,* 42 Minn. L. Rev. 969 (1958).

Recently in the United Kingdom, the Select Committee on Medical Ethics of the House of Lords considered carefully "the ethical, legal, and clinical implications of a person's right to withhold consent to life-prolonging treatment" and related

issues of physician-assisted suicide and voluntary euthanasia. The Select Committee's unanimous report affirmed the crucial importance of the very distinctions which the Second Circuit dismissed as meaningless. *Report of the Select Committee on Medical Ethics* (January 1994), *passim*.

While "strongly endors[ing] the right of the competent patient to refuse consent to any medical treatment," the Select Committee concluded that such refusal "is far removed from the right to request assistance in dying." *Id.* at 48. The Select Committee noted the powerful emotional sympathy which anyone must feel for the plight of the desperately ill and appreciated the pain, physical deterioration, disfigurement, and other burdens which they can suffer and which understandably can make them, and their loved ones, long for "a peaceful and easy death." *Id.* These are, of course, the very circumstances which the Second Circuit described in such detail and which seemed to color its views so strongly. *Quill v. Vacco*, 80 F.3d at 720-721. But the Select Committee ultimately concluded that even the combination of such sympathetic considerations and the arguments advanced by proponents of physician-assisted suicide were not:

> . . . sufficient reason to weaken society's prohibition of intentional killing. That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal. We do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia.
>
> * * *
>
> One reason for this conclusion is that we do not think it possible to set secure limits on voluntary euthanasia. Some witnesses told us that to legalise voluntary euthanasia was a discrete step which need have no other consequences. But as we said in our

> introduction, issues of life and death do not lend themselves to clear definition, and without that it would not be possible to frame adequate safeguards against non-voluntary euthanasia if voluntary euthanasia were to be legalised. It would be next to impossible to ensure that all acts of euthanasia were truly voluntary, and that any liberalisation of the law was not abused. Moreover to create an exception to the general prohibition of intentional killing would inevitably open the way to its further erosion whether by design, by inadvertence, or by the human tendency to test the limits of any regulation. These dangers are such that we believe that any decriminalisation of voluntary euthanasia would give rise to more, and more grave, problems than those it sought to address.
>
> * * *
>
> We are also concerned that vulnerable people -- the elderly, lonely, sick or distressed -- would feel pressure, whether real or imagined, to request early death. We accept that, for the most part, requests resulting from such pressure or from remediable depressive illness would be identified as such by doctors and managed appropriately. Nevertheless we believe that the message which society sends to vulnerable and disadvantaged people should not, however obliquely, encourage them to seek death, but should assure them of our care and support in life.

Report of the Select Committee at 48-49.

Amici submit that the Select Committee's exceptionally thoughtful consideration of these issues casts a withering light on the Second Circuit's analysis, so very different in depth, quality, and conclusion.

What the Second Circuit's opinion lacks in logical persuasiveness it scarcely makes up in legal analysis. The court cited no precedent for its decision, understandably, since it asserted that "no 'right' to assisted suicide ever has been recognized in any state in the United States." *Quill v. Vacco*, 80 F.3d at 724.[1] However, the court did offer an extended discussion of *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 110 S.Ct. 2841 (1990), in justification of its contention that physician-assisted suicide cannot be distinguished from refusal of medical treatment. But there the State of Missouri clearly "recognized a right to refuse treatment embodied in the common law doctrine of informed consent," and it just as clearly joined the majority of states in criminalizing assistance in suicide. *Id.* at 268, 280. Still, this Court in *Cruzan* saw no occasion to comment on any glaring logical inconsistency in noting these two policies of the State (though the case, admittedly, involved the different issue of the standard of proof required to demonstrate a comatose patient's wish to forgo life-sustaining food and water, artificially administered), observing rather that there could be "no gainsaying" Missouri's "interest in the protection and preservation of human life," in furtherance of which it could "properly decline to make judgments about the 'quality of life' that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." *Id.* at 282. *Amici* therefore suggest that *Cruzan* is odd authority for the Second Circuit to cite in support of its conclusion that a state cannot draw rational distinctions between the refusal of medical treatment and assisted suicide.

---

[1] It should be noted, however, that the Eleventh Circuit's *en banc* declaration of a substantive due process liberty interest in physician-assisted suicide had preceded the Second Circuit's decision in *Quill v. Vacco* by only a brief interval. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995), *rev'd* 79 F.3d 790 (1996) (en banc).

Finally, the Second Circuit deserves criticism for the rashness with which it snatched the issue of physician-assisted suicide from its proper place in the realm of public debate and legislative evaluation and presumed to settle it by declaring a hitherto unrecognized constitutional right. Such intemperate action by the judicial branch has several undesirable effects. It prevents important and controversial issues of public policy from being adequately developed in the give-and-take of the open marketplace of ideas. It deprives the people of their right to reach an ultimate resolution of such issues through the democratic institutions created for that purpose. And, insidiously, it lessens the respect of citizens for the judicial branch of government and fosters an unfortunate perception of the federal courts as elitist bodies where unelected judges enshrine their personal predilections as binding law.

CONCLUSION

Wherefore, for the reasons stated above, *amici* ask that the writ of certiorari prayed for by petitioners should issue.

Respectfully submitted,

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Supreme Court of the United States

October Term, 1995

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF AMICI CURIAE STATES OF CALIFORNIA, ARKANSAS, COLORADO, FLORIDA, GEORGIA, IOWA, MARYLAND, MASSACHUSETTS, MICHIGAN, MONTANA, NEBRASKA, SOUTH CAROLINA, TENNESSEE, VIRGINIA, AND WASHINGTON IN SUPPORT OF PETITIONERS DENNIS C. VACCO, ET AL.

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QUESTION PRESENTED FOR REVIEW

Whether New York's prohibition of assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution.

TABLE OF CONTENTS

Page

I. INTEREST OF THE AMICI CURIAE 1

II. REASONS FOR GRANTING THE WRIT 2

A. Certiorari Should be Granted To Establish That A Decision by the People of a State to Prohibit Assisted Suicide Does Not Violate the Equal Protection Clause of the Fourteenth Amendment 6

1. The Withdrawal of Life-Sustaining Treatment Is Not the Equivalent of Suicide or Assisted Suicide, and Thus, New York's Prohibition of Assisted Suicide Does Not Create Any Class of Similarly Situated Persons 7

2. New York's Prohibition of Assisted Suicide Is Rationally Related to Numerous Important Governmental Objectives 11

B. Certiorari Should be Granted to Reaffirm the Essential Role of the States in our Federal System and the Power of the People to Directly Govern Their Own Affairs 17

III. CONCLUSION 20

TABLE OF AUTHORITIES

Page

CASES

Application of President & Directors of Georgetown College, Inc., 118 U.S.App.D.C. 80, 331 F.2d 1000 (1964), *cert. denied*, 377 U.S. 978 (1964) 14

Bartling v. Superior Court, 163 Cal.App.3d 186, 209 Cal.Rptr. 220 (1984) 5, 14

Blackburn v. State, 23 Ohio St. 146 (Ohio 1872) 4, 15

Bouvia v. Superior Court, 179 Cal.App.3d 1127, 225 Cal.Rptr. 297 (1986) 5

Bowers v. Hardwick, 478 U.S. 186 (1986) 16

City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985) 12

Commonwealth v. Mink, 123 Mass. 422 (Mass. 1877) 4

Compassion in Dying v. State of Washington, 49 F.3d 586 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996) 14

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) 20

Cruzan v. Director, Missouri Dept. of Public Health, 497 U.S. 261 (1990) ..... *passim*

Cruzan v. Harmon, 760 S.W.2d 408 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) 5, 15, 19

Dallas v. Stanglin, 490 U.S. 19 (1989) 11, 17

Dandridge v. Williams, 397 U.S. 471 (1970) 12

TABLE OF AUTHORITIES – Continued

Page

DeGrella v. Elston, 858 S.W.2d 698 (Ky. 1993) 5

Donaldson v. Lungren, 2 Cal.App.4th 1614, 4 Cal.Rptr.2d 59 (1992) 5, 14, 19

Garcia v. San Antonio Metro., 469 U.S. 528 (1985) 2, 19, 20

In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) 5

In re Eric J., 25 Cal.3d 522, 159 Cal.Rptr. 317 (1979) 7

In re Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976) 5

Kadrmas v. Dickinson Public Schools, 487 U.S. 450 (1988) 6

Lochner v. New York, 198 U.S. 45 (1905) 2

Matter of Storar, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981) 8, 9

McGowan v. Maryland, 366 U.S. 420 (1961) 12

Middlesex Ethics Committee v. Garden State Bar Association, 457 U.S. 423 (1982) 14

New State Ice Co. v. Liebmann, 285 U.S. 262 (1932) 20

Olmstead v. United States, 277 U.S. 438 (1928), *overruled by Katz v. United States*, 389 U.S. 347 (1967) 18

Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973) 16

People v. Adams, 216 Cal.App.3d 1431, 265 Cal.Rptr. 568 (1990) 5

People v. Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994) 1, 4, 5, 11, 19

TABLE OF AUTHORITIES – Continued

Page

Personnel Administrator of Massachusetts v. Feeney, 442 U.S. 256 (1979) 8

Planned Parenthood v. Casey, 505 U.S. 833 (1992) 15, 16

Quill v. Koppell, 870 F.Supp. 78, 82 (S.D.N.Y. 1994), *aff'd in part and rev'd in part sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) 8

Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) ..... *passim*

Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986) 9

Roe v. Wade, 410 U.S. 113 (1973) 9, 16

San Antonio School District v. Rodriguez, 411 U.S. 1 (1973) ..... *passim*

State v. Jones, 86 S.C. 17, 67 S.E. 160 (S.C. 1910) 4

State v. Willis, 121 S.E.2d 854 (N.C. 1961) 4

Thor v. Superior Court, 5 Cal.4th 725, 21 Cal.Rptr.2d 357 (1993) 5

Tigner v. Texas, 310 U.S. 141 (1940) 11

Von Holden v. Chapman, 87 A.D.2d 66, 450 N.Y.S.2d 623 (1982) 5

CONSTITUTIONAL PROVISIONS

U.S. Const. amend. X 2

U.S. Const. amend. XIV, § 1 ..... *passim*

TABLE OF AUTHORITIES – Continued

Page

STATUTES

18 Pa. Cons. Stat. Ann.
§ 2505 4

Ala. Code
§ 13A-6-1 4

Alaska Stat.
§ 11.41.120(a)(2) 3

Ariz. Rev. Stat. Ann.
§ 13-1103(A)(3) 3

Ark. Stat. Ann.
§ 5-10-104(a)(2) 3

Cal. Pen. Code
§ 401 3

Colo. Rev. Stat.
§ 18-3-104(1)(b) 3

Conn. Gen. Stat.
§ 53a-56(a)(2) 3

Del. Code Ann.
tit. 11, § 645 3

Fla. Stat. Ann.
§ 782.08 3

Ga. Code Ann.
§ 16-5-5(b) 3

TABLE OF AUTHORITIES – Continued

Page

Ia. Code
§§ 707A.1, 707A.2 and 707A.3 3

Ill. Comp. Stat.
ch. 720, 5/12-31 3

Ind. Stat. Ann.
§ 35-42-1-2.5(b) 3

Kan. Stat. Ann.
§ 21-3406 3

Ky. Rev. Stat.
§ 216:302 3

La. Rev. Stat.
§ 14:32.12 3

Me. Rev. Stat. Ann.
tit. 17-A, § 204 3

Minn. Stat. Ann.
§ 609.215 3

Miss. Code Ann.
§ 97-3-49 3

Mo. Ann. Stat.
§ 565.023(1)(2) 4

Mont. Code Ann.
§ 45-5-105 4

TABLE OF AUTHORITIES – Continued

Page

N.D. Cent. Code
§ 12.1-16-04 4
N.H. Rev. Stat. Ann.
§ 630:4 4
N.J. Stat. Ann.
§ 2C:11-6 4
N.M. Stat. Ann.
§ 30-2-4 4
Neb. Rev. Stat.
§ 28-307 4
New York Penal Law
§ 120.30 ..... 4, 7
§ 125.15 ..... 4, 7
New York Public Health Law, Article 29-B
§§ 2960-2979 9
§ 2964 10
New York Public Health Law, Article 29-C
§§ 2980-2994 9
§ 2981 10
§ 2989(3) 10
Okla. Stat. Ann.,
tit. 21, §§ 813-818 4

TABLE OF AUTHORITIES – Continued

Page

P.R. Laws Ann.
tit. 33, § 4009 4
S.D. Codified Laws Ann.
§ 22-16-37 4
Tenn. Code Ann.
§ 39-13-216 4
Tex. Penal Code Ann.
§ 22.08 4
V.I. Code Ann.
tit. 14, § 2141 4
Wash. Rev. Code Ann.
§ 9A.36.060 4
Wis. Stat. Ann.
§ 940.12 4
Wyoming Stat.
§ 6-2-107 4

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TABLE OF AUTHORITIES – Continued

Page

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Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Constitutional Law Quarterly, No. 3, 799 (1994) 5

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I. INTEREST OF THE AMICI CURIAE

The case below represents a return to an era, long since past, when the principles of federalism were all but eliminated by the mistaken notion that the Fourteenth Amendment authorizes courts to substitute their judgment for that of the States in matters of economic and social welfare. In an opinion which significantly departs from this Court's present-day equal protection jurisprudence, the Second Circuit has declared that New York's prohibition of assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment to the extent that it prohibits a physician from prescribing a lethal dose of medication for self-administration by a mentally-competent, terminally ill patient in the final stages of his or her illness. *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996) (hereinafter "*Quill*"). In so holding, the Second Circuit found that New York's prohibition of assisted suicide did not further, and thus was not rationally related to, ***any*** legitimate state interest. *Quill, supra*, 80 F.3d at 729-731.

More troubling than the serious flaws in the Court's analysis is the impact of its holding. If allowed to stand, the Second Circuit's opinion will precipitate a fundamental change in the long-standing policies of a majority of States to prevent suicide and assisted suicide. "[A]ll states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of nondeadly force to thwart suicide attempts." *People v. Kevorkian*, 447 Mich. 436, 479, 527 N.W.2d 714, 732 (1994) (footnote omitted), *cert. denied*, 115 S.Ct. 1795 (1995). A majority of States impose criminal penalties on those who assist another to commit suicide. As Justice Scalia has observed, " . . . American law has always accorded the State the power to prevent, by force if necessary, suicide . . . " *Cruzan v. Director, Missouri Dept. of Public Health*, 497 U.S. 261, 293 (1990) (Scalia J., concurring). However, if allowed to stand, the Second Circuit's holding will invalidate New York's prohibition of assisted suicide and, at the same time, provide authority for equal protection challenges to similar state statutes across the Nation.

The protection and preservation of human life is, without question, the quintessential duty and responsibility of the sovereign States in our federal system of government. The power of the States to fulfill this most important of responsibilities, through the exercise of the police power, is likewise unquestionable.[1] Indeed, as Justice Harlan observed in his famous dissent in *Lochner v. New York*, "[a]ll the cases agree that . . . [the States' police] power extends at least to the protection of the lives, the health, and the safety of the public against the injurious exercise by any citizen of his own rights." *Lochner v. New York*, 198 U.S. 45, 65 (1905) (Harlan, J., dissenting).

At stake in this case are, first and foremost, the lives of the people, both those who wish to die, and those who wish to live no matter what their circumstances. Also at stake is the sovereign power of the States to protect and preserve those lives *without* a federal requirement that the State " . . . make judgments about the 'quality' of life that a particular individual may enjoy, . . . " *Cruzan v. Director, Missouri Dept. of Public Health*, 497 U.S. 261, 282 (1990). The resolution of this question will arguably affect more lives than any case which this Court will confront in the foreseeable future. It will also determine whether "the States *as States* have [any] legitimate interests which the National Government is bound to respect even though its laws are supreme." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 581 (1985) (O'Connor, J., dissenting) (italics original, citation omitted, insert added).

II. REASONS FOR GRANTING THE WRIT

The question presented in this case is whether New York's prohibition of assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment. The resolution of this question will have profound implications for the continued viability of the essential role of the States in our federal system

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[1] "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States, respectively, or to the people." U.S. Const. amend. X.

of government. In *San Antonio School District v. Rodriguez*, this Court cautioned that:

> "It must be remembered . . . that every claim arising under the Equal Protection Clause has implications for the relationship between national and state power under our federal system. Questions of federalism are always inherent in the process of determining whether a State's laws are to be accorded the traditional presumption of constitutionality, or are to be subjected instead to rigorous judicial scrutiny. While '[t]he maintenance of the principles of federalism is a foremost consideration in interpreting any of the pertinent constitutional provisions under which this Court examines state action,' it would be difficult to imagine a case having a greater potential impact on our federal system than the one now before us, in which we are urged to abrogate systems of financing public education presently in existence in virtually every State." *San Antonio School District v. Rodriguez*, 411 U.S. 1, 44 (1973) (footnote omitted).

Twenty-three years after this Court decided *San Antonio School District v. Rodriguez*, " . . . a case having a greater potential impact on our federal system . . . " has arrived – a case in which prohibitions of assisted suicide presently in existence in the vast majority of States are at stake.[2] *Id.*

---

[2] At least forty States, Puerto Rico and the Virgin Islands, impose criminal penalties on those who assist another to commit suicide. The following states and territories have statutes which impose criminal penalties for aiding, assisting, causing, or promoting suicide: Alaska Stat., § 11.41.120(a)(2); Ariz. Rev. Stat. Ann., § 13-1103(A)(3); Ark. Stat. Ann., § 5-10-104(a)(2); Cal. Pen. Code, § 401; Colo. Rev. Stat., § 18-3-104(1)(b); Conn. Gen. Stat., § 53a-56(a)(2); Del. Code Ann., tit. 11, § 645; Fla. Stat. Ann., § 782.08; Ga. Code Ann. § 16-5-5(b); Ill. Comp. Stat. ch. 720, 5/12-31; Ind. Stat. Ann., § 35-42-1-2.5(b); Ia. Code, §§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session; Kan. Stat. Ann., § 21-3406; Ky. Rev. Stat., § 216:302; La. Rev. Stat., § 14:32.12; Me. Rev. Stat. Ann., tit. 17-A, § 204; Minn. Stat. Ann., § 609.215; Miss. Code Ann., § 97-3-49; Mo. Ann. Stat.,

Perhaps the best evidence of its potential impact on the Nation is the sheer number of conflicts created by the Second Circuit's opinion. In *Quill*, the Second Circuit declared that New York's statutes prohibiting assisted suicide violate the Equal Protection Clause of the Fourteenth Amendment. *Quill, supra*, 80 F.3d at 731. That holding conflicts squarely with the recent holding of the Michigan Supreme Court in *People v. Kevorkian*.[3] In addition, the rationale utilized by the Second Circuit in rendering its holding directly conflicts with numerous state court opinions. The centerpiece of the Second Circuit's opinion is unquestionably its conclusion that terminally ill persons on life support who wish to "hasten their deaths" by directing the withdrawal of such systems are similarly situated with others who wish to "hasten death by self-

§ 565.023(1)(2); Mont. Code Ann., § 45-5-105; Neb. Rev. Stat., § 28-307; N.H. Rev. Stat. Ann., § 630:4; N.J. Stat. Ann., § 2C:11-6; N.M. Stat. Ann., § 30-2-4; N.Y. Penal Law, §§ 120.30, 125.15(3); N.D. Cent. Code, § 12.1-16-04; Okla. Stat. Ann., tit. 21, §§ 813-818; 18 Pa. Cons. Stat. Ann., § 2505; P.R. Laws Ann., tit. 33, § 4009; S.D. Codified Laws Ann., § 22-16-37; Tenn. Code Ann., § 39-13-216; Tex. Penal Code Ann., § 22.08; V.I. Code Ann., tit. 14, § 2141; Wash. Rev. Code Ann., § 9A.36.060; and Wis. Stat. Ann., § 940.12. The following states have statutes which impose criminal penalties for negligent homicide which are broad enough to encompass aiding, assisting, causing or promoting suicide: Ala. Code, § 13A-6-1; and Wyo. Stat., § 6-2-107. The following states impose criminal penalties by case law for assisting a suicide: *Commonwealth v. Mink*, 123 Mass. 422, 428-429 (Mass. 1877); *People v. Kevorkian*, 447 Mich. 436, 527 N.W.2d 714 (Mich. 1994); *Blackburn v. State*, 23 Ohio St. 146, 163 (Ohio 1872); *State v. Jones*, 86 S.C. 17, 67 S.E. 160, 165 (S.C. 1910); and *State v. Willis*, 121 S.E.2d 854 (N.C. 1961).

[3] *People v. Kevorkian*, 447 Mich. 436, 480 n. 57, 527 N.W.2d 714, 732 n. 57 (1994) ("For reasons apparent in our analysis of the due process claims, we also reject the argument that Michigan's assisted suicide statute is invalid because it denies equal protection to terminally ill persons who want help in ending their lives, i.e., it denies them a right enjoyed by terminally ill persons who opt to forgo or discontinue life-sustaining medical treatment. As we explained, the two situations are not the same for purposes of constitutional analysis."), *cert. denied*, 115 S.Ct. 1795 (1995).

administering prescribed drugs."[4] *Quill, supra*, 80 F.3d at 729. However, " . . . those courts that have found a right to refuse to begin or to continue life-sustaining medical treatment have done so only after concluding that such refusal is wholly different from the act of suicide."[5] Numerous state legislatures have likewise recognized this fundamental distinction.[6] Finally, in *Cruzan v. Director, Missouri Dept. of Public Health*, 497

[4] At the threshold, it should be recognized that there is a danger in using euphemistic language such as "hastening death" when referring to the act of suicide. Such language, which is often utilized by proponents of assisted suicide, has a tendency to obfuscate the reality of the important questions which end-of-life cases generally present. *See People v. Kevorkian*, 447 Mich. 436, 464 n. 27, 527 N.W.2d 714, 725 n. 27 (1994), *cert. denied*, 115 S.Ct. 1795 (1995), and *Cruzan v. Harmon*, 760 S.W.2d 408, 412 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

[5] *People v. Kevorkian*, 447 Mich. 436, 480, 527 N.W.2d 714, 732 (1994) (footnote omitted), *cert. denied*, 115 S.Ct. 1795 (1995). *See, e.g., Von Holden v. Chapman*, 87 A.D.2d 66, 450 N.Y.S.2d 623, 627 (1982) ("essential dissimilarity" between right to decline medical treatment and any right to end one's life); *In re Conroy*, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985); *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 1145, 225 Cal.Rptr. 297, 306 (1986); *Bartling v. Superior Court*, 163 Cal.App.3d 186, 196, 209 Cal.Rptr. 220, 225-226 (1984); *People v. Adams*, 216 Cal.App.3d 1431, 1440, 265 Cal.Rptr. 568, 573-574 (1990); *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1619-1623, 4 Cal.Rptr.2d 59, 61-64 (1992) and cases cited therein; *Thor v. Superior Court*, 5 Cal.4th 725, 742, 21 Cal.Rptr.2d 357, 367-368 (1993); *DeGrella v. Elston*, 858 S.W.2d 698, 706-707 (Ky. 1993). *Cf. In re Quinlan*, 70 N.J. 10, 51-52 and n. 9, 355 A.2d 647, 669-670 and n. 9 (neither attempted nor aiding suicide implicated in circumstances similar to those presented), *cert. denied*, 429 U.S. 922 (1976). *See also* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 10 n. 34 (1985), and cases cited therein.

[6] *See* Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Constitutional Law Quarterly, No. 3, 799, 806 n. 25 (1994) (" . . . legislatures that have codified the right to refuse treatment in the same legislation reject any affirmative act to end life."), *citing* natural death/living will statutes of forty States.

U.S. 261 (1990), this Court "assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition" but, at the same time, recognized Missouri's important interest in the protection and preservation of human life, noting that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan, supra*, 497 U.S. at 279-280 (footnote omitted). Plainly, the majority in *Cruzan* had no difficulty at all distinguishing the withdrawal of life-sustaining treatment, on the one hand, and the act of suicide, on the other.

Notwithstanding this overwhelming authority to the contrary, the Second Circuit erroneously concluded that the two situations are indistinguishable. *Quill, supra*, 80 F.3d at 729. As will be seen, the Second Circuit's failure to make this critical distinction infected its constitutional analysis, contributed to its misplaced reliance on right-to-refuse treatment cases, and led directly to its ultimate erroneous conclusion. The conflicts created by the Second Circuit's opinion, involving an issue of such exceptional and profound nationwide importance, can only be resolved – indeed, must be resolved – by the final authoritative voice of this Court.

A. Certiorari Should be Granted To Establish That A Decision by the People of a State to Prohibit Assisted Suicide Does Not Violate the Equal Protection Clause of the Fourteenth Amendment

The Equal Protection Clause of the Fourteenth Amendment provides that no State shall " . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const. amend. XIV, § 1. It is well-settled that:

> "Unless a statute provokes strict judicial scrutiny because it interferes with a fundamental right or discriminates against a suspect class, it will ordinarily survive an equal protection attack so long as the challenged classification is rationally related to a legitimate governmental purpose." *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 457-458 (1988) (internal quotes and citations omitted).

The Second Circuit correctly found that New York's statutes prohibiting assisted suicide neither impinge upon fundamental rights nor create suspect classifications and, accordingly, that the rational basis standard of review applied. *Quill, supra*, 80 F.3d at 726-727. However, it failed to properly apply that standard in accordance with the clear precedents of this Court. Simply put, while the Second Circuit invoked rational basis language, that was not the standard it applied.

1. The Withdrawal of Life-Sustaining Treatment Is Not the Equivalent of Suicide or Assisted Suicide, and Thus, New York's Prohibition of Assisted Suicide Does Not Create Any Class of Similarly Situated Persons

"The first prerequisite to a meritorious claim under the equal protection clause is a showing that the state has adopted a classification that affects two or more *similarly situated* groups in an unequal manner." *In re Eric J.*, 25 Cal.3d 522, 530, 159 Cal.Rptr. 317, 320 (1979) (italics original, citation and footnote omitted). However, as a review of the challenged statutes plainly reveals, that cannot possibly be established here.

Section 125.15 of the New York Penal Law provides, in pertinent part, that "[a] person is guilty of manslaughter in the second degree when: . . . [h]e intentionally . . . aids another person to commit suicide." Violation of section 125.15 has been designated a class C felony. *Id.* Section 120.30 of the New York Penal Law provides that "[a] person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide." Violation of section 120.30 has been designated a class E felony. *Id.*

Both statutes clearly apply to all persons and, thus, on their face, create no classifications at all. Both statutes prohibit all persons from performing specific *acts*, *i.e.*, aiding another to attempt or commit suicide.[7] Thus, to the extent that New

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[7] Neither statute has been applied in this case, *i.e.*, none of the respondents have been charged with any violation of section 125.15 or

York law classifies at all, the classification is clearly neutral. "[T]he Fourteenth Amendment guarantees equal laws, not equal results." *Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 273 (1979). In *Quill*, the Second Circuit found a classification created not by the terms of the challenged statutes, or by their application in a particular case, but rather based on its conclusion that the withdrawal of life-sustaining treatment is the equivalent of the act of suicide. Thus, under the Second Circuit's reasoning, terminally ill persons who request the withdrawal of life-sustaining treatment are similarly situated with other persons who wish to commit suicide and assisted suicide. *Quill, supra*, 80 F.3d at 729. However, in addition to being contrary to the overwhelming weight of authority cited above, even the authorities cited by the Second Circuit do not support this conclusion.

The Second Circuit cited *Matter of Storar* and *Eichner v. Dillon* (decided together), 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981), for the proposition that:

> "In both these cases, the New York Court of Appeals recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so." *Quill, supra*, 80 F.3d at 727.

Storar and *Eichner*, however, are both right to refuse treatment cases. The phrase "hasten his death" incorrectly implies that the New York Court of Appeals approved not only the right to refuse unwanted medical treatment, but also the act of suicide. It did not. Moreover, in relying on these cases, the Second Circuit ignored the far more relevant part of the majority opinion which recognized that:

> "The State has a legitimate interest in protecting the lives of its citizens. . . . It may, by statute, prohibit them from engaging in specified activities, including medical procedures which are inherently hazardous

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120.30. While a grand jury proceeding was instituted against one of the respondents, Dr. Quill, no indictment was returned. *Quill v. Koppell*, 870 F.Supp. 78, 82 (S.D.N.Y. 1994), *aff'd in part and rev'd in part sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

> to their lives (*Roe v. Wade, supra*, 410 U.S. pp. 150, 154, 93 S.Ct. pp. 725, 727)." *Matter of Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, *cert. denied*, 454 U.S. 858 (1981).

Furthermore, a review of the majority opinion reveals even more evidence that the New York Court of Appeals did not impliedly approve of suicide (*i.e.*, "hastening death"). First, the New York Court of Appeals specifically noted that the State's interest in preventing suicide was *not* implicated in the *Eichner* case. *Matter of Storar, supra*, 52 N.Y.2d at 377 n. 6. Second, recognizing the need for judicial restraint, the majority found it unnecessary to address the dissent's endorsement of a limited form of passive euthanasia. *Matter of Storar, supra*, 52 N.Y.2d at 370 n. 2. In view of the foregoing, the Second Circuit's reliance on *Storar* and *Eichner* was clearly misplaced.

The Second Circuit also relied on *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337 (1986), for the proposition that the New York Court of Appeals had

> " . . . recognized the right to bring on death by refusing medical treatment not only as a fundamental common-law right but also as coextensive with [a] patient's liberty interest protected by the due process clause of our State Constitution." *Quill, supra*, 80 F.3d at 727 (internal quotes and citation omitted, insert original).

Again, this is incorrect. In *Rivers*, the New York Court of Appeals did not mention any "right to bring on death", a phrase which again implies approval of the act of suicide. Rather, the right which the court recognized, as evidenced from the text of the opinion itself, was *the right to refuse unwanted medical treatment*. *Rivers, supra*, 67 N.Y.2d at 493.

The Second Circuit also relied on both Article 29-B of New York Public Health Law, entitled "Orders Not to Resuscitate", sections 2960-2979, and Article 29-C, entitled "Health Care Agents and Proxies", sections 2980-2994, for the proposition that:

> " . . . the New York legislature [has] placed its imprimatur upon the right of competent citizens to hasten death by refusing medical treatment and by

> directing physicians to remove life-support systems already in place." *Quill, supra*, 80 F.3d at 727.

Again, this is incorrect. As a review of these statutes plainly reveals, the New York legislature did not recognize any right to "hasten death", rather, it recognized the right to refuse medical treatment.[8] Moreover, in relying on these statutes, the Second Circuit ignored the far more relevant statute, *i.e.*, New York Public Health Law, Article 29-C, § 2989(3), which specifically provides that:

> "This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law."

This statute directly contradicts the Second Circuit's contention that the New York legislature has either expressly or impliedly approved of suicide or assisted suicide. Plainly, it has not. In summary, none of the New York authorities discussed above support the contention that the State of New York has recognized a right to commit suicide or, as the Second Circuit phrased it, a right to "hasten death". Rather, what the State of New York has recognized is the right to refuse unwanted medical treatment, regardless of the consequences of that refusal.

The final authority relied upon by the Second Circuit in its effort to equate the withdrawal of life-sustaining treatment with the act of suicide is this Court's opinion in *Cruzan v. Director, Missouri Dept. of Public Health*, 497 U.S. 261 (1990). However, like its reliance on New York law, that reliance is entirely misplaced. While the Second Circuit discussed several portions of the *Cruzan* opinion at length, it ignored the far more relevant portion of the opinion for present purposes, *i.e.*, the recognition by the majority that even in the face of a right to refuse medical treatment, the States may

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[8] *See, e.g.*, New York Public Health Law, Article 29-B, § 2964 (recognizing right of adult with capacity to consent to an order not to resuscitate), and Article 29-C, § 2981 (allowing for appointment of an agent "to make health care decisions on the principal's behalf").

properly assert important interests in the protection and preservation of human life, and in the prevention of both suicide and assisted suicide. *Cruzan, supra*, 497 U.S. at 280.

In *Cruzan*, this Court also discussed the underpinnings of the right to refuse medical treatment, *i.e.*: (1) the right of bodily integrity, and (2) "[t]he logical corollary of the doctrine of informed consent . . . the right not to consent, that is, to refuse treatment." *Cruzan, supra*, 497 U.S. at 269 and 270. When a terminally ill person accepts life-sustaining treatment, he or she is authorizing the invasion of bodily integrity which necessarily accompanies such treatment. The fact that such persons must sacrifice their bodily integrity in order to live plainly demonstrates they are not similarly situated with any other class. Furthermore, "[a] person may refuse life-sustaining medical treatment *because* the treatment itself is a violation of bodily integrity." *People v. Kevorkian*, 447 Mich. 436, 480 n. 59, 527 N.W.2d 714, 732 n. 59 (1994), *cert. denied*, 115 S.Ct. 1795 (1995) (emphasis added).

In sharp contrast, suicide and assisted suicide do not implicate either the right of bodily integrity or the right not to consent, *i.e.*, the right to refuse unwanted medical treatment. Simply stated, suicide and assisted suicide are so significantly different from the withdrawal or withholding of unwanted medical treatment, and its legal underpinnings, that a person exercising the right to refuse such treatment cannot be considered similarly situated with a person seeking to commit suicide or assisted suicide. The two situations simply are not the same for constitutional purposes. "The Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." *Tigner v. Texas*, 310 U.S. 141, 147 (1940).

2. New York's Prohibition of Assisted Suicide Is Rationally Related to Numerous Important Governmental Objectives

Review under the rational basis standard " . . . is the most relaxed and tolerant form of judicial scrutiny under the Equal Protection Clause." *Dallas v. Stanglin*, 490 U.S. 19, 26 (1989).

In discussing the rational basis standard in *McGowan v. Maryland*, the Court stated that:

> "Although no precise formula has been developed, the Court has held that the Fourteenth Amendment permits the States a wide scope of discretion in enacting laws which affect some groups of citizens differently than others. The constitutional safeguard is offended only if the classification rests on grounds wholly irrelevant to the achievement of the State's objective. State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their laws result in some inequality. A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it." *McGowan v. Maryland*, 366 U.S. 420, 425-426 (1961). See also *Dandridge v. Williams*, 397 U.S. 471, 485 (1970).

As Justice Stewart observed in his concurring opinion in *San Antonio School District v. Rodriguez*, 411 U.S. 1, 60 (1973), "[t]his doctrine is no more than a specific application of one of the first principles of constitutional adjudication – the basic presumption of constitutional validity of a duly enacted state or federal law. [citation omitted]" Thus, under the rational basis standard, legislation is first presumed valid and then, shielded by that presumption, tested to determine if the classification it creates is rationally related to a legitimate state interest.[9]

In discussing this presumption in *Quill*, however, the Second Circuit stated "[t]he general rule . . . is that state legislation carries a presumption of validity **if** the statutory classification is 'rationally related to a legitimate state interest.' [citation omitted]" *Quill, supra*, 80 F.3d at 725 (emphasis added). This is incorrect. The existence of the presumption of validity is not conditioned upon a subsequent finding of rational relationship; rather, the presumption *precedes* application

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[9] *See City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985) ("The general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest. [citations omitted]").

of the standard itself. The Second Circuit's apparent failure to accord New York's statutes the presumption of validity to which they are entitled may provide at least some explanation why the Court utilized such a strict, skeptical, means-end analysis to review the challenged statutes.

While the Second Circuit did identify several important state interests implicated by New York's prohibition of assisted suicide, it went on to conclude that:

> "The New York statutes prohibiting assisted suicide, which are similar to the Washington statute, do not serve any of the state interests noted, *in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment.*" *Quill, supra*, 80 F.3d at 730 (italics added).

This holding, like its misidentification of a similarly situated class, is based on the Second Circuit's failure to differentiate between the withdrawal of life-sustaining treatment and the act of suicide. Once this recurrent error is removed from the analysis, however, it immediately becomes clear that New York's prohibition of assisted suicide directly furthers, and thus is rationally related to, several important state interests. Those interests include, but are not limited to: (1) the protection and preservation of human life;[10] (2) the prevention of suicide;[11] (3) preventing the fraud, errors and abuse which would

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[10] *Cruzan v. Director, Missouri Dept. of Public Health*, 497 U.S. 261, 280 (1990).

[11] "Suicide is the eighth leading cause of death in the United States." New York State Task Force Report, *When Death is Sought – Assisted Suicide and Euthanasia in the Medical Context* (May 1994), at 9 (footnote omitted). "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." *Id.*, at 11. Furthermore, "[l]ike other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.*, at 13 (footnote omitted).

accompany acceptance of suicide and assisted suicide;[12] (4) maintaining the ethical integrity of the medical profession;[13] (5) protecting the poor and minorities from exploitation;[14] (6) protecting handicapped persons from societal indifference;[15] and (7) protecting innocent third parties.[16]

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[12] *Cruzan, supra*, 497 U.S. at 281 ("[E]ven where family members are present, [t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations. [citation omitted, internal quotes omitted]"). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr. 59, 64 (1992) ("The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence."), and *Donaldson, supra*, 2 Cal.App.4th at 1624 ("Third parties, even family members, do not always act to protect the person whose life will end.").

[13] *Cf. Middlesex Ethics Committee v. Garden State Bar Association*, 457 U.S. 423, 434 (1982) (important state interest in "maintaining and assuring the professional conduct of professional attorneys it licenses"). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1620, 4 Cal.Rptr.2d 59, 62 (1992) (recognizing state interest in maintaining the ethical integrity of the medical profession). In reaffirming its long-standing opposition to physician assisted suicide, the American Medical Association has declared that physician-assisted suicide " . . . threatens the very core of the medical profession's ethical integrity" and is " . . . fundamentally inconsistent with the physician's professional role." American Medical Association, Council on Ethical and Judicial Affairs, *Code of Medical Ethics Reports*, Vol. V, No. 2 (July 1994), Report 59, *Physician-Assisted Suicide*, 269 and 274, respectively.

[14] *Quill, supra*, 80 F.3d at 730, *citing Compassion in Dying v. State of Washington*, 49 F.3d 586, 592-593 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[15] *Quill, supra*, 80 F.3d at 730, *citing Compassion in Dying v. State of Washington*, 49 F.3d 586, 592-593 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[16] *Application of President & Directors of Georgetown College, Inc.*, 118 U.S.App.D.C. 80, 331 F.2d 1000, 1008 (1964), *cert. denied*, 377 U.S. 978 (1964). *See also Bartling v. Superior Court*, 163 Cal.App.3d 186, 195 n. 6, 209 Cal.Rptr. 220, 225 n. 6 (1984).

The Second Circuit's application of the rational basis standard was further flawed by its improper insertion of quality-of-life considerations into its analysis which it used to discount the State's important interest in the protection and preservation of human life. *Quill, supra*, 80 F.3d at 729-730. Such quality-of-life considerations are directly contrary to this Court's holding in *Cruzan* that:

> "[W]e think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan v. Director, Missouri Dept. of Public Health*, 497 U.S. 261, 282 (1990).

The dangers inherent in using such quality-of-life considerations are well-recognized. "Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives." *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). Such an analysis also disregards the irrefutable principle that all lives, from beginning to end and irrespective of physical or mental condition, are under the full protection of the law.

> "The life of those to whom life has become a burden – of those who are hopelessly diseased or fatally wounded – nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live." *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 295 (1990) (Scalia, J., concurring), *citing Blackburn v. State*, 23 Ohio St. 146, 163 (1873).

In discounting the State's important interest in the protection and preservation of human life, the Second Circuit also cited this Court's opinion in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). That citation was particularly surprising in that *Casey* itself reaffirms the States' " . . .

legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child." *Casey, supra*, 505 U.S. at 846. Nevertheless, the Second Circuit relied on *Casey* when posing the following rhetorical question:

> "What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life,' *Planned Parenthood v. Casey*, 505 U.S. 833, 851, 112 S.Ct. 2791, 2807, 120 L.Ed.2d 674 (1992), when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state is preserving life compels the answer to these questions: 'None.' " *Quill, supra*, 80 F.3d at 730.

There are at least two fundamental flaws in the Second Circuit's reliance on *Casey* for this proposition. First, it is well-settled that "[i]t is not the province of this Court to create substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio School District v. Rodriguez*, 411 U.S. 1, 33 (1973). That, however, was precisely what the Second Circuit did in this case. Within the liberty interest described by this Court in *Casey*, the Second Circuit has created a new right "to have drugs prescribed to end life during the final stages of a terminal illness". *Quill, supra*, 80 F.3d at 730. Second, this is precisely the sort of "unlimited right to do with one's body as one pleases" which this Court has consistently and soundly rejected. *See Roe v. Wade*, 410 U.S. 113, 154 (1973); *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986); and *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 (1973), *citing, inter alia*, constitutionally unchallenged laws against suicide.

Finally, in *Quill*, the Second Circuit suggested that New York could achieve its objective of avoiding undue influence on the elderly and infirm to choose death by " . . . establish[ing] rules and procedures to assure that all choices [to commit assisted suicide] are free of such pressures." *Quill, supra*, 80 F.3d at 730 (inserts added). With respect to the definition of "terminal illness", the Second Circuit suggested:

> "Again, New York may define that stage of illness with greater particularity, require the opinion of more than one physician or impose any other obligation upon patients and physicians who collaborate in hastening death. [footnote omitted]" *Quill, supra*, 80 F.3d at 731.

In the footnote which accompanies the quoted text, the Second Circuit went on to suggest numerous other ways in which the State of New York could achieve its objectives but still allow assisted suicide. *Quill, supra*, 80 F.3d at 731 n. 4. However, this same argument was rejected by the Court in *Dallas v. Stanglin*, 490 U.S. 19 (1989), and, as in that case, demonstrates a " . . . missapprehen[sion] of the nature of rational-basis scrutiny, which is the most relaxed and tolerant form of judicial scrutiny under the Equal Protection Clause." *Dallas, supra*, 490 U.S. at 26-27. The fact that a State may, if it chooses, seek to achieve its legitimate objectives through other means does not, in any way, establish that the means actually selected are either irrational or arbitrary. Indeed, as this Court observed with respect to the problems of financing and managing a statewide public school system:

> "The very complexity of the problems . . . suggests that there will be more than one constitutionally permissible method of solving them, and that, within the limits of rationality, the legislature's efforts to tackle the problems should be entitled to respect." *San Antonio School District v. Rodriguez*, 411 U.S. 1, 42 (1973) (internal quotes and citation omitted).

B. Certiorari Should be Granted to Reaffirm the Essential Role of the States in our Federal System and the Power of the People to Directly Govern Their Own Affairs

With the ever-increasing power of medical science to prolong life, even in the face of what would otherwise be terminal illness, the States have had to strike a balance between the rights of the individual and the demands of

organized society. That balance is grounded in the States' recognition of their responsibility to protect both individual rights and, at the same time, the lives of those who wish to live no matter what their circumstances. In striking that balance, the States have drawn a line between an individual's "right to be let alone",[17] on the one hand, and intentionally killing oneself, with or without assistance, on the other. That balance, now a national consensus, is represented by statutes in a majority of states which both codify an individual's right to refuse unwanted medical treatment and, in the same legislation, reject any affirmative act to end life. The exercise of the right to refuse life-sustaining medical treatment permits an individual to determine, at least to some extent, when he or she will die. The exercise of this right does not, however, condemn such an individual to suffer either an undignified death or excruciating pain. Rather, at the same time an individual elects to forego life-sustaining treatment, he or she may choose to accept palliative care which will help insure both a dignified death and well-controlled symptoms.[18]

Whether this balance should be abandoned and the line redrawn to permit an individual to commit suicide without state interference, and then redrawn yet again to permit assisted suicide, is a matter appropriately left for the people to decide, through their duly elected representatives or by

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[17] *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), *overruled by Katz v. United States*, 389 U.S. 347, 352-353 (1967).

[18] Palliative care is designed to relieve distressing symptoms in dying patients and includes measures to alleviate pain and suffering, together with the provision of emotional, social and spiritual support for the patient. The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying*, 71-73 (1987). *See also*, American Medical Association, Council on Ethical and Judicial Affairs, *Code of Medical Ethics Reports*, Vol. V, No. 2 (July 1994), Report 59, *Physician-Assisted Suicide*, 269, 272-273 (describing advances in hospice care).

initiative ballot.[19] The principles of federalism embodied in our Constitution require no less. Simply put, as Justice Scalia noted in the right to refuse treatment context, " . . . the federal courts have no business in this field . . . " *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring). In addition, as the Missouri Supreme Court has observed, the courts are simply not an appropriate forum for resolution of broad questions of public policy.

> "Broad policy questions bearing on life and death issues are more properly addressed by representative assemblies. These have vast fact and opinion gathering and synthesizing powers unavailable to courts; the exercise of these powers is particularly appropriate where issues invoke the concerns of medicine, ethics, morality, philosophy, theology and law. Assuming change is appropriate, this issue demands a comprehensive resolution which courts cannot provide." *Cruzan v. Harmon*, 760 S.W.2d 408, 426 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

As the States continue to grapple with the difficult questions presented by the ever-increasing ability of medical technology to prolong life, the corresponding need to allow the States to serve as laboratories for change becomes paramount. Indeed, as this Court has recognized, "[t]he science of government . . . is the science of experiment, . . . " *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985) (citation and internal quotes omitted).

> "To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic

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[19] *See People v. Kevorkian*, 447 Mich. 436, 481-482, 527 N.W.2d 714, 733 (1994), *cert. denied*, 115 S.Ct. 1795 (1995), and *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr.2d 59, 64 (1992).

> experiments without risk to the rest of the country. . . . " *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

If allowed to stand, the Second Circuit's opinion in *Quill* will effectively extinguish the power of the States to continue to serve as laboratories for change on an issue that arguably will affect more lives than any other issue the States will face in the foreseeable future. If allowed to stand, it will also " . . . invite[] an unelected federal judiciary to make decisions about which state policies it favors and which ones it dislikes." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985). At the same time, it will " . . . relegate the States to precisely the trivial role that opponents of the Constitution feared they would occupy." *Garcia, supra*, 469 U.S. at 575 (Powell, J., dissenting) (footnote omitted).

> "The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary." *Compassion in Dying v. State of Washington*, 79 F.3d 790, 858 (9th Cir. 1996) (Kleinfeld, C.J., dissenting).

III. CONCLUSION

For all the foregoing reasons, amici States respectfully request that the Court grant certiorari in this case.

Respectfully submitted,

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MOTION FILED

JUN 17 1996

No. 95-1858

In the Supreme Court of the United States

OCTOBER TERM, 1995

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE OF CATHOLIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

---

MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

The Catholic Medical Association ("CMA") respectfully moves this Court for leave to file a brief *amicus curiae* in support of Petitioners. Petitioners have consented to the filing of this brief. Respondents, however, have refused consent, thus necessitating the filing of this motion.

The CMA is a non-profit, public service organization founded in 1932. The CMA promotes the principles of Roman Catholic medical ethics in science and in the practice of medicine. The CMA includes more than one thousand physicians and coordinates the activities of more than 80 regional Catholic physicians' guilds in the United States and Canada.

BEST AVAILABLE COPY

Since 1932, the CMA has published *The Linacre Quarterly*, a leading scholarly journal on biomedical ethics. The CMA's companion Linacre Institute routinely produces studies on important medical and moral issues. The CMA also serves as a resource for the medical community, holding annual conferences where scholars and health care professionals meet and interact.

The CMA, as a potential *amicus curiae* before this Court, would contribute its professional and ethical perspective on physicians and their role in treating the terminally ill. Since its inception, the CMA has brought the practical experience and scholarly expertise of its members to bear on important societal issues. The CMA wishes to share with this Court the insights of the scholars and physicians that are its practicing members.

In addition to its own experience, the CMA hopes to inform the Court of a central theme in Catholic medical ethics, the distinction between meeting death with peace and dying at one's own hand.

For decades, Catholic religious and medical leaders have differentiated between suicide and the withdrawal of life support. In rejecting such a distinction, the Second Circuit broke from a venerable historical tradition. As a unique part of that tradition, the CMA asks for the opportunity to be heard.

The motion of the CMA for leave to file the accompanying brief *amicus curiae* in support of Petitioners should be granted.

Respectfully submitted,

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JUNE 1996

QUESTION PRESENTED

Whether New York's prohibition of assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
INTEREST OF THE AMICUS CURIAE	1
REASONS FOR GRANTING THE PETITION	2
CERTIORARI SHOULD BE GRANTED TO ESTABLISH THAT A STATE MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT	4
A. Assisted Suicide Is Not The Same As The Withdrawal Of Life Support	5
1. The Opinion Below Conflicts With The Decisions Of Eighteen State Courts Of Last Resort	8
2. The Opinion Below Conflicts With The Overwhelming Consensus Of The Medical Community	12
B. States Have Legitimate Interests In Prohibiting Assisted Suicide	15
CONCLUSION	19

TABLE OF AUTHORITIES

CASES

	Page
Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983)	2a
Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984)	2a
Blackburn v. State, 23 Ohio St. 146 (1872)	2, 17, 7a
Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986)	2a
In re Browning, 568 So. 2d 4 (Fla. 1990)	11, 1a
City of Cleburne v. Cleburne Living Ctr., 473 U.S. 432 (1985)	5, 15
In re Colyer, 99 Wash. 2d 114, 660 P.2d 738 (1983)	12
Commonwealth v. Bowen, 13 Mass. 356 (1816)	7a
Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (*en banc*), *modified*, 1996 WL 294445 (9th Cir. May 28, 1996)	4
In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985)	9, 2a
Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990)	*passim*
Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990)	16-17
Dallas v. Stanglin, 490 U.S. 19 (1989)	15
De Grella ex rel. Parrent v. Elston, 858 S.W.2d 698 (Ky. 1993)	10, 1a
In re Doe, 411 Mass. 512, 583 N.E.2d 1263, *cert. denied*, 503 U.S. 950 (1992)	1a
Donaldson v. Lundgren, 2 Cal. App. 4th 1614, 4 Cal. Rptr. 2d 59 (1992)	2a
In re Eichner, 102 Misc. 2d 184, 423 N.Y.S.2d 580 (Sup. Ct. 1979), *aff'd as modified sub nom. Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (1980), *aff'd as modified sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981)	7, 2a
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TABLE OF AUTHORITIES—Continued

	Page
Foody v. Manchester Mem. Hosp., 40 Conn. Supp. 127, 482 A.2d 713 (1984)	2a
Fosmire v. Nicoleau, 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990)	10, 1a
In re Gardner, 534 A.2d 947 (Me. 1987)	11, 1a
In re Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified on other grounds*, 757 P.2d 534 (Wash. 1988)	11-12, 1a
Kadrmas v. Dickinson Pub. Sch., 487 U.S. 450 (1988)	16
In re L.W., 167 Wis. 2d 53, 482 N.W.2d 60 (1992)	12, 1a
In re Lawrence, 579 N.E.2d 32 (Ind. 1991)	1a
Leach v. Akron General Med. Ctr., 68 Ohio Misc. 1, 426 N.E.2d 809 (Ct. Com. Pl. 1980)	2a
McConnell v. Beverly Enters., 209 Conn. 692, 553 A.2d 596 (1989)	1a
McGowan v. Maryland, 366 U.S. 420 (1961)	15
McKay v. Bergstedt, 106 Nev. 808, 801 P.2d 617 (1990)	1a
McMahan v. State, 168 Ala. 70, 53 So. 89 (1910)	7a
In re P.V.W., 424 So. 2d 1015 (La. 1982)	11, 2a
People v. Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1795 (1995)	3, 15, 17, 18, 1a
Plyler v. Doe, 457 U.S. 202 (1982)	4
In re Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976)	9, 10, 11
Rasmussen v. Fleming, 154 Ariz. 207, 741 P.2d 674 (1987)	10, 1a
Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986)	8
In re Rosebush, 195 Mich. App. 675, 491 N.W.2d 633 (1992)	2a
San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1 (1973)	5
Satz v. Perlmutter, 362 So.2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980)	2a
In re Severns, 425 A.2d 156 (Del. Ch. 1980)	2a
State v. Jones, 86 S.C. 17, 67 S.E. 160 (1910)	7a

TABLE OF AUTHORITIES—Continued

	Page
State v. McAfee, 259 Ga. 579, 385 S.E.2d 651 (1989)	1a
State v. Willis, 255 N.C. 473, 121 S.E.2d 854 (1961)	7a
In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981)	7
Thor v. Superior Court, 5 Cal. 4th 725, 855 P.2d 375, 21 Cal. Rptr. 2d 357 (1993)	1a
United States v. Brandt (the Medical Case), II Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10 (1949)	3
United States v. Stanley, 483 U.S. 669 (1987)	3
Vance v. Bradley, 440 U.S. 93 (1979)	9
STATUTES AND STATE CONSTITUTIONAL PROVISIONS	
Ala. Code § 13A-6-4 (1995)	7a
Ala. Code § 22-8A-10 (1995)	3a
Alaska Stat. § 11.41.120(a)(2) (1995)	6a
Alaska Stat. § 18.12.080(f) (1995)	3a
Ariz. Rev. Stat. Ann. § 13-1103(A)(3) (1995)	6a
Ariz. Rev. Stat. Ann. § 36-3210 (1995)	3a
Ark. Code Ann. § 5-10-104(a)(2) (Michie 1995)	6a
Ark. Code Ann. § 20-17-210(g) (Michie 1995)	3a
Cal. Health & Safety Code § 7191.5(g) (West 1995)	3a
Cal. Penal Code § 401 (West 1995)	6a
Colo. Rev. Stat. Ann. § 15-18-112(1) (West 1995)	3a
Colo. Rev. Stat. Ann. § 18-3-104(1)(b) (West 1995)	6a
Conn. Gen. Stat. Ann. § 19a-575 (West 1995)	3a
Conn. Gen. Stat. Ann. § 53a-56(a)(2) (West 1995)	6a
Del. Code Ann. tit. 11, § 645 (1995)	6a
Del. Code Ann. tit. 16, § 2507 (1995)	3a
D.C. Code Ann. § 6-2430 (1995)	3a
D.C. Code Ann. § 21-2212 (1995)	3a
Fla. Stat. Ann. § 765.309(1) (West 1995)	3a

TABLE OF AUTHORITIES—Continued

	Page
Fla. Stat. Ann. § 782.08 (West 1995)	6a
Ga. Code Ann. § 16-5-5(b) (1995)	6a
Ga. Code Ann. § 31-32-9 (1995)	3a
Ga. Code Ann. § 31-36-2 (1995)	3a
Haw. Rev. Stat. § 327D-13 (1995)	3a
Haw. Rev. Stat. § 707-702 (1995)	6a
Idaho Code § 39-161(1) (1995)	3a
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Ill. Comp. Stat. ch. 755, para. 35/9 (Smith-Hurd 1995)	3a
Ill. Comp. Stat. ch. 755, para. 40/50 (Smith-Hurd 1995)	3a
Ind. Code Ann. § 16-36-1-13 (West 1995)	3a
Ind. Code Ann. § 16-36-4-19 (West 1995)	3a
Ind. Code Ann. § 35-42-1-2.5(b) (West 1995)	6a
Iowa Code Ann. § 144A.11.6 (West 1995)	3a
Iowa Code Ann. § 144B.12.2 (West 1995)	3a
Iowa Code Ann. §§ 707A.2, 707A.3 (1996)	6a
Kan. Stat. Ann. § 21-3406 (1995)	6a
Kan. Stat. Ann. § 65-28,109 (1995)	3a
Ky. Rev. Stat. Ann. § 216.302 (Baldwin 1995)	6a
Ky. Rev. Stat. Ann. § 311.637 (Michie/Bobbs-Merrill 1995)	3a
La. Const. art. I, § 20	10
La. Rev. Stat. Ann. § 14:32.12 (West 1995)	6a
La. Rev. Stat. Ann. § 1299.58.10 (West 1995)	3a
Me. Rev. Stat. Ann. tit. 17-A, § 204 (West 1995)	6a
Me. Rev. Stat. Ann. tit. 18-A, § 5-813 (West 1995)	3a
Md. Code Ann., Health-Gen § 5-611 (1995)	4a
Mass. Gen. Laws Ann. ch. 201D, § 12 (West 1995)	4a
Mich. Comp. Laws Ann. § 700.496(20) (West 1995)	4a
Mich. Comp. Laws Ann. § 752.1027 (West 1995)	6a
Minn. Stat. Ann. § 145B.14 (West 1995)	4a
Minn. Stat. Ann. § 609.215 (West 1995)	6a
Miss. Code Ann. § 41-41-117(2) (1993)	4a
Miss. Code Ann. § 97-3-49 (1993)	6a
Mo. Ann. Stat. § 459.055(5) (Vernon 1995)	4a

TABLE OF AUTHORITIES—Continued

	Page
Mo. Ann. Stat. § 565.023(1) (2) (Vernon 1995)	6a
Mont. Code Ann. § 45-5-105 (1993)	6a
Mont. Code Ann. § 50-9-205(7) (1995)	4a
Neb. Rev. Stat. § 20-412(7) (1995)	4a
Neb. Rev. Stat. § 28-307 (1995)	6a
Nev. Rev. Stat. § 449.670(2) (1993)	4a
N.H. Rev. Stat. Ann. § 137-H:10(II) (1995)	4a
N.H. Rev. Stat. Ann. § 630:4 (1995)	6a
N.J. Stat. Ann. § 2C:11-6 (West 1995)	6a
N.J. Stat. Ann. § 26:2H-54(e) (West 1995)	4a
N.M. Stat. Ann. § 24-7-8 (Michie 1996)	4a
N.M. Stat. Ann. § 30-2-4 (Michie 1995)	6a
N.Y. Penal Law § 120.30 (McKinney 1995)	6, 6a
N.Y. Penal Law § 125.15 (McKinney 1995)	6, 18, 6a
N.Y. Pub. Health Law §§ 2960-79 (McKinney 1995)	8
N.Y. Pub. Health Law §§ 2980-94 (McKinney 1995)	8
N.Y. Pub. Health Law § 2964 (McKinney 1995)	8
N.Y. Pub. Health Law § 2981 (McKinney 1995)	8
N.Y. Pub. Health Law § 2989 (McKinney 1995)	8, 4a
N.C. Gen. Stat. § 90-320(b) (1995)	4a
N.D. Cent. Code § 12.1-16-04 (1995)	6a
N.D. Cent. Code § 23-06.4-01 (1995)	4a
N.D. Cent. Code § 23-06.5-01 (1995)	4a
Ohio Rev. Code Ann. § 2133.12(d) (Baldwin 1996)	4a
Okla. Stat. Ann. tit. 21, § 813 (West 1995)	6a
Okla. Stat. Ann. tit. 63, § 3101.12(g) (West 1995)	4a
Or. Rev. Stat. § 127.570 (1995)	4a
Or. Rev. Stat. § 163.125(b) (1995)	6a
18 Pa. Cons. Stat. Ann. § 2505 (1995)	7a
20 Pa. Cons. Stat. Ann. § 5402(b) (1995)	4a
P.R. Laws Ann. tit. 33, § 4009 (1990)	7a
R.I. Gen. Laws § 23-4.10-9(f) (1995)	4a
R.I. Gen. Laws § 23-4.11-10(f) (1995)	4a
S.C. Code Ann. § 44-77-130 (Law. Co-op. 1993)	4a
S.D. Codified Laws Ann. § 22-16-37 (1996)	7a
S.D. Codified Laws Ann. § 34-12D-20 (1996)	4a
Tenn. Code Ann. § 32-11-110 (1995)	4a

TABLE OF AUTHORITIES—Continued

	Page
Tenn. Code Ann. § 39-13-216 (1995)	7a
Tex. Health & Safety Code Ann. § 672.020 (West 1995)	4a
Tex. Penal Code Ann. § 22.08 (West 1995)	7a
Utah Code Ann. § 75-2-1118 (1995)	4a
V.I. Code Ann. tit. 14, § 2141 (1994)	7a
Vt. Stat. Ann. tit. 18, § 5260 (1995)	4a
Va. Code Ann. § 54.1-2990 (Michie 1995)	4a
Wash. Rev. Code Ann. § 9A.36.060 (West 1995)	7a
Wash. Rev. Code Ann. § 70.122.100 (West 1995)	4a
W. Va. Code § 16-30-10 (1995)	4a
Wis. Stat. Ann. § 154.11(6) (West 1995)	5a
Wis. Stat. Ann. § 940.12 (West 1995)	7a
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MISCELLANEOUS

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TABLE OF AUTHORITIES—Continued

	Page
Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021 (1992)	14
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On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF AMICUS CURIAE OF CATHOLIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICUS CURIAE

The Catholic Medical Association ("CMA") is a national organization of Roman Catholic physicians and scholars. As more fully set forth in its motion for leave to file this brief, the CMA seeks to assist this Court by presenting the considered experience of its members, who practice daily in the field of medical ethics.

REASONS FOR GRANTING THE PETITION

"I will give no deadly medicine to anyone if asked, nor suggest any such counsel" [1]
Hippocrates of Cos
c. 410 B.C.

"Physician assisted suicide is fundamentally incompatible with the physician's role as healer" [2]
American Medical Association
1994 A.D.

From the dawn of the healing art until the present, physicians have been asked to heal rather than to kill, to save lives rather than to end them. Societies throughout history, including our own, have recognized life and its protection as an unqualified good,[3] indeed, as *the* good from which other societal goods derive.[4] Physicians serve society by maintaining life, by healing patients who request their help, and by promoting health, which is fundamental to the enjoyment of so many of life's virtues. Conversely, American society has always condemned physicians who stray from the healing path, who use their knowledge to harm, or who depart from their role as guardians of society's interest in life.[5]

[1] Hippocrates, *The Oath* (W.H.S. Jones trans., Loeb Classical Library 1923).

[2] American Medical Ass'n, *Code of Medical Ethics* § 2.211 (1994).

[3] Society's unqualified commitment to life runs throughout traditional jurisprudence. In *Blackburn v. State*, 23 Ohio St. 146, 163 (1872), for example, the Ohio Supreme Court observed that:

> The life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Accord, 4 William Blackstone, *Commentaries on the Law of England* *189 ("[t]he suicide is guilty of [an offense] against the King, who hath an interest in the preservation of all his subjects"). Similarly, this Court has acknowledged the constitutionality of such a fundamental choice for life:

> We think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . . .

Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 282 (1990).

[4] Pope John Paul II, Encyclical Letter *Evangelium Vitae* ¶ 66 (March 25, 1995) (noting that life is God's gift and that suicide is a rejection of that gift; *accord*, 1 William Blackstone, *Commentaries on the Laws of England* *125 ("[l]ife is the immediate gift of God, a right inherent by nature in every individual").

On April 2, 1996, the Second Circuit departed from that tradition. Invoking an equal protection analysis, the court below held that there is no distinction between assisted suicide and the withholding or withdrawal of treatment. Pet. App. 30a-31a. The court then invalidated New York's statutory distinction between assisted suicide and the withdrawal of life support, holding that it is "not rationally related to any legitimate state interest." *Id.* at 35a.

New York now seeks review of that decision. In support, the CMA notes that the decision below directly conflicts with: (1) eighteen state supreme courts that have distinguished between assisted suicide and the withdrawal of life support; (2) the overwhelming consensus of the medical community that assisting suicide and withdrawing life support fundamentally differ; (3) this Court's decision in *Cruzan* that States may constitutionally assert an unqualified interest in life; and (4) the Michigan Supreme Court's decision in *People v. Kevorkian* [6] that prohibitions against physician-assisted suicide advance legitimate state interests.

In addition, the difficulties with the decision below are illustrated by a comparison between it and the Ninth

[5] *See, e.g., United States v. Brandt (the Medical Case)*, II Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10, at 181 (1949); *see also United States v. Stanley*, 483 U.S. 669, 710 (1987) (O'Connor, J., concurring in part and dissenting in part).

[6] 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1795 (1995).

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Circuit's recent decision in *Compassion in Dying v. Washington*.[7] Although the Ninth Circuit's decision also invalidates a state law prohibiting assistance in suicide, the court's opinion and the opinion below each reject the rationale adopted by the other. The Ninth Circuit rejects the equal protection approach followed by the court below, and instead announces a substantive due process right to physician-assisted suicide. 79 F.3d at 816. The court below, by contrast, rejects any such due process right but then invalidates the New York statutes on equal protection grounds. Pet. App. 19a, 30a-35a. This disagreement is not surprising, because both decisions lack a proper constitutional foundation.

Review is needed now to dispel the notion, advanced by courts of appeals in two of the nation's most populous circuits, that the States are constitutionally powerless to prohibit physicians and others from promoting or assisting in suicide. Such dangerous precedents should not be permitted to percolate any further in the lower federal courts without review by this Court.

CERTIORARI SHOULD BE GRANTED TO ESTABLISH THAT A STATE MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT.

While the Equal Protection Clause requires that "all persons similarly circumstanced should be treated alike, . . . [t]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." *Plyler v. Doe*, 457 U.S. 202, 216

[7] 79 F.3d 790 (9th Cir. 1996) (en banc), *modified*, 1996 WL 294445 (9th Cir. May 28, 1996). The Ninth Circuit's decision in *Compassion in Dying* became final on May 29, 1996. Earlier, the court of appeals, on its own motion, directed the parties to submit supplemental briefs on whether the case should be reheard en banc before all twenty-eight judges of the Ninth Circuit. On May 29, the court decided not to conduct such a hearing. On June 10, 1996, this Court stayed the Ninth Circuit's mandate, pending the timely filing and disposition of a petition for certiorari.

(1982) (internal quotations and citations omitted). Instead, disparate treatment will normally pass equal protection scrutiny if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985).

In addressing Respondents' equal protection challenge, the court of appeals asked first whether the New York statutes at issue provide disparate treatment to similarly situated groups and then, having answered that question in the affirmative, whether the alleged "inequality" is rationally related to a legitimate state interest. Pet. App. 20a-35a. Although it is far from clear that this Court's decisions mandate such a two-step inquiry (rather than a more direct examination of whether a statutory classification is supported by a rational basis), the more fundamental problem with the court of appeals' decision is that it answers incorrectly both questions posed, and appears to apply a more stringent level of constitutional scrutiny, even while paying lip service to the "rational basis" test. As New York observes, "[t]he Second Circuit's decision creates an ill-defined new substantive constitutional right, brought forth in the name of equal protection . . . ." Pet. 13-14. This Court has previously rejected such misuse of the Equal Protection Clause, stating that "[i]t is not the province of this Court to create substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33 (1973).

A. Assisted Suicide Is Not The Same As The Withdrawal Of Life Support.

The moral, civil, and common law has always regarded the refusal or withdrawal of medical treatment as fundamentally different from suicide.[8] There is, moreover, an

[8] *See* Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735, 753-60 (1995); Thomas J.

obvious common-sense basis for this distinction. Declining or discontinuing medical intervention so as to allow the natural order to proceed and death to come when it will is qualitatively different from prescribing or administering toxic chemicals so as to cause death by unnatural means. Yet, with the stroke of a pen, the court of appeals has chosen to equate suicide with the decision of some patients not to artificially extend their lives through medical technology. The equivalence postulated by the court of appeals is illusory.

The Second Circuit invalidated two statutes: New York Penal Law § 125.15 and New York Penal Law § 120.30 (McKinney 1995). Section 125.15 provides that "[a] person is guilty of manslaughter in the second degree when: . . . [h]e intentionally . . . aids another person to commit suicide." Section 120.30 provides that "[a] person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide."

The court of appeals began its equal protection analysis by concluding that Sections 125.15 and 120.30 treat terminally ill patients on life support differently from anyone else. How the court arrived at this conclusion, however, remains a mystery. Neither statute creates any facial classification. Instead, each merely prohibits particular conduct (*i.e.*, assisting another to commit or to attempt suicide).[9] The court purportedly discovered a surreptitious classification when it read New York's living will statute in conjunction with New York's prohibitions against assisted suicide. Pet. App. 26a-27a. Contrary to the court's view, however, neither the living will statute nor any of the other authorities cited supports a conclusion

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Marzen et al., *Suicide: A Constitutional Right?* 24 Duq. L. Rev. 1, 9-13 (1985).

[9] No record evidence suggests that either statute has been applied to disadvantage any group. Indeed, none of the parties has been prosecuted under either statute. Pet. App. 71a.

that New York has recognized a general right of its citizens to "hasten death."

The court of appeals cited the companion cases of *In re Storar*[10] and *Eichner v. Dillon* for the proposition that "the New York Court of Appeals [has] recognized the right of a competent, terminally ill patient to hasten his death upon proper proof of his desire to do so." Pet. App. 25a. An examination of *Storar* and *Eichner*, however, shows that both cases discuss the right to refuse medical treatment rather than any right to "hasten death." Indeed, the New York Court of Appeals expressly stated that:

> the State has a legitimate interest in protecting the lives of its citizens. . . . It may, by statute, prohibit them from engaging in specified activities, including medical procedures which are inherently hazardous to their lives.

52 N.Y.2d at 377, 420 N.E.2d at 71, 438 N.Y.S.2d at 273. The *Eichner* Court also observed that the State's interest in preventing suicide is not implicated in the withdrawal of life support.[11]

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[10] 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981).

[11] 52 N.Y.2d at 377 n.6, 420 N.E.2d at 71 n.6, 438 N.Y.S.2d at 273 n.6 ("[i]n other cases the State may be able to assert additional interests, such as, prevention of suicide or, perhaps, protection of minor children or dependents. Those concerns are inapplicable here. Brother Fox's condition was not self-inflicted").

Eichner involved two members of a Roman Catholic order, Father Eichner and Brother Fox. Brother Fox was in a permanent vegetative state and dependent on a respirator. Father Eichner, Fox's religious superior and legal guardian, sought to have the respirator withdrawn. The Second Circuit's reliance on *Eichner* is particularly misplaced. Certainly Father Eichner was not asking for permission to assist in Brother Fox's suicide. It would have been morally reprehensible to him as a Catholic priest to do so.

The Second Circuit also invoked *Rivers v. Katz*[12] for the proposition that New York has recognized a right to hasten death. Pet. App. 25a-26a. Like *Storar* and *Eichner*, however, *Rivers* involved the right to refuse unwanted medical treatment.[13]

Nor do New York's living will statutes[14] establish any general right of New York citizens to hasten death. Instead, they merely codify the common law right to refuse medical treatment.[15] Indeed, the New York legislature itself drew a sharp distinction between suicide and the withdrawal of life support when it provided that:

> [t]his article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law.

New York Public Health Law § 2989 (1995).

1. *The Opinion Below Conflicts With The Decisions Of Eighteen State Courts Of Last Resort.*

New York is not alone in recognizing the distinction between assisted suicide and withdrawal of life support. In equating the two (Pet. App. 31a), the Second Circuit

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[12] 67 N.Y.2d 485, 495 N.E.2d 337, 504 N.Y.S.2d 74 (1986).

[13] 67 N.Y.2d at 493, 495 N.E.2d at 341, 504 N.Y.S.2d at 78 ("[i]n *Storar*, we recognized that a patient's right to determine the course of his medical treatment was paramount to what might otherwise be the doctor's obligation to provide medical care, and that the right of a competent adult to refuse medical treatment must be honored, even though the recommended treatment may be beneficial or even necessary to preserve the patient's life").

[14] New York Public Health Law art. 29-B, §§ 2960-79; New York Public Health Law art. 29-C, §§ 2980-94.

[15] *See, e.g.*, New York Public Health Law § 2964 (recognizing right of adult with capacity to consent to an order not to resuscitate), and § 2981 (allowing for appointment of an agent "to make health care decisions on principal's behalf").

placed itself into direct conflict with at least eighteen state courts of last resort. The relevant state court decisions are listed in Appendix A.

In considering whether different groups are similarly situated for equal protection purposes, this Court has often relied on "common-sense proposition[s]" regarding the relative characteristics of the persons involved. *See, e.g., Vance v. Bradley*, 440 U.S. 93, 112 (1979) (relying on "the common-sense proposition that aging—almost by definition—inevitably wears us all down"). At least eighteen state courts have similarly drawn a common-sense distinction between forgoing life support and committing suicide.

The legal distinction between suicide and the withdrawal of life support was clearly appreciated by the New Jersey Supreme Court in *In re Quinlan*, 70 N.J. 10, 43, 355 A.2d 647, 665, *cert. denied*, 429 U.S. 922 (1976). In *Quinlan*, the guardians of a young comatose woman sought permission to withdraw the artificial means of life support that were keeping her alive. Faced with the argument that such a course would amount to suicide or homicide, the New Jersey Supreme Court responded that it "would see a real distinction between the self-infliction of deadly harm and a self determination against artificial life support or radical surgery, in the face of irreversible, painful and certain imminent death." 70 N.J. at 43, 355 A.2d at 665. The court further observed that "there would be no criminal homicide" in removing Ms. Quinlan's ventilator because her "ensuing death would not be homicide but rather expiration from existing natural causes." 70 N.J. at 51, 355 A.2d at 669-70.

The New Jersey Supreme Court later addressed assisted suicide and the withdrawal of life support in *In Re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). This time the court squarely held that "declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide." 98 N.J. at 350-51, 486 A.2d at 1224.

With medical science's increasing ability to sustain life through artificial means, state statutes allowing individuals to express their willingness to forgo such means of life support have proliferated. All 50 states and the District of Columbia have enacted living will statutes distinguishing the withdrawal of life support from assisted suicide. These statutes are listed in Appendix B. Against the background of such laws, other state courts have followed *Quinlan*'s lead. The Arizona Supreme Court, for example, specifically ruled that "[a]sserting the right to refuse medical treatment is not tantamount to committing suicide." *Rasmussen v. Fleming*, 154 Ariz. 207, 218, 741 P.2d 674, 685 (1987).

Likewise, in *De Grella ex rel. Parrent v. Elston*, the Kentucky Supreme Court contrasted " '[m]ercy killing' and 'euthanasia' or any other 'affirmative or deliberate act to end life' [which] are fundamental violations of the common law," with "withdrawal of nutrition and hydration from a person . . . in a persistent vegetative state . . . [which] is medically recognized as fitting the definition of 'permit[ing] the natural process of dying' . . . ." 858 S.W.2d 698, 707 (Ky. 1993). The New York Court of Appeals has embraced the same distinction. *See Fosmire v. Nicoleau*, 75 N.Y.2d 218, 227, 551 N.E.2d 77, 82, 551 N.Y.S.2d 876, 881 (1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act").[16]

Quinlan's progeny have often confronted fundamental state law questions in drawing their distinction between withdrawing life support on the one hand and suicide or euthanasia on the other. The Louisiana State Constitution, for example, includes an explicit prohibition against euthanasia. La. Const. art. I, § 20 ("No law shall subject any person to euthanasia . . . ."). Nevertheless, the Louisiana Supreme Court has drawn a principled distinc-

[16] For a comprehensive study of New York's historic opposition to assisted suicide, see John A. Alesandro, *Comment: Physician-Assisted Suicide and New York Law*, 57 Alb. L. Rev. 820 (1994).

tion between euthanasia and withdrawing life support. *See In re P.V.W.*, 424 So.2d 1015, 1022 (La. 1982) (holding that "[t]hese extraordinary means of preserving a person's 'existence' in an irreversible vegetative coma have little to do with the continuation or the ending of 'life', and removal of such systems under highly restricted circumstances cannot reasonably be construed as violative of the constitutional prohibition against euthanasia").

Not only do the States agree that withdrawal of life support differs from suicide, but they generally agree on why this is so. Beginning with *Quinlan*, state courts have consistently held that when life support is removed, the patient's preexisting condition, and not the removal of the life support, is the legal cause of death. *See, e.g., Quinlan*, 70 N.J. at 51, 355 A.2d at 669-70. By contrast, the person who ingests a lethal substance causes his own death; there is no preexisting condition to blame. Following such reasoning, the Florida Supreme Court held that "suicide is not an issue when . . . the discontinuance of life support 'in fact will merely result in [the patient's] death, if at all, from natural causes.' " *In re Browning*, 568 So.2d 4, 14 (Fla. 1990) (citation omitted). The Maine Supreme Court agreed that a patient's "decision to live without artificial life-sustaining procedures would not constitute suicide since the grievous injuries resulting in his present condition were not self-inflicted. . . . His decision not to receive [medical procedures], far from constituting suicide, is a choice to allow to take its course the natural dying process set in moion by his physiological inability to chew or swallow." *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987) (citations omitted). Finally, the Washington Supreme Court expressly disassociated itself from an endorsement of suicide or euthanasia, though finding that a patient has a right to withhold medical or artificial life support devices. The court reasoned that "in none of these cases can the withholding of life sustaining devices be deemed the cause of [the patient's] death. The cause of her death

will be [the] disease." *In re Grant*, 109 Wash. 2d 545, 563-64, 747 P.2d 445, 455-56 (1987), *modified on other grounds*, 757 P.2d 534 (Wash. 1988); *accord*, *In re Colyer*, 99 Wash. 2d 114, 123, 660 P.2d 738, 743 (1983).

The Second Circuit apparently misunderstood this causation analysis, which turns on the fundamental tort law distinction between cause in fact and legal or proximate cause. Although withdrawal of life support may be the "but for" cause of a patient's death, the law has long recognized a valid distinction between cause in fact and proximate or "responsible" cause. *See, e.g.*, W. Page Keeton et al., *Prosser and Keeton on the Law of Torts* § 42, at 273 (5th ed. 1984). Although in both instances an act of the doctor or the patient may be the "but for" cause of the patient's death, in suicide the act will also be the proximate cause. From any common-sense perspective, it is not irrational to say that a person who either refuses life support or requests that it be withdrawn dies from his preexisting condition, while the person who ingests deadly medicine dies at his own hand. That is why state court after state court has rejected the equivalence asserted by the court below between suicide and withdrawing life support. In the words of the Wisconsin Supreme Court, "No one can dispute that the withdrawal of treatment, especially artificial feeding, will result in the death of a patient. However, it is equally indisputable that the result is the natural death of the body," *In re L.W.*, 167 Wis. 2d 53, 81, 482 N.W.2d 60, 71 (1992); *see also* 167 Wis. 2d at 92, 482 N.W.2d at 75 ("[r]efusing medical treatment is not suicide").

2. *The Opinion Below Conflicts With The Overwhelming Consensus Of The Medical Community.*

The medical community has traditionally drawn a sharp distinction between physician-assisted suicide and withdrawing the means of life support. As the American Medical Association, for example, has observed:

> [t]he withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmalficence [*sic*]. The physician is obligated only to offer sound medical treatment and to refrain from providing treatments that are detrimental, on balance, to the patient's well-being. When a physician withholds or withdraws a treatment on the request of a patient, he or she has fulfilled the obligation to offer sound treatment to the patient. The obligation to offer treatment does not include an obligation to impose treatment on an unwilling patient. In addition, the physician is not providing a harmful treatment. Withdrawing or withholding is not a treatment, but the forgoing of a treatment.

AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* (1994). Similarly, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical & Behavioral Research, has commented that:

> [a]lthough competent patients . . . have the legal and ethical authority to forgo some or all care, this does not mean that patients may insist on particular treatments. The care available from health care professionals is generally limited to what is consistent with [professional standards].

President's Commission for the Study of Ethical Problems in Medicine and Biomedical & Behavioral Research, *Deciding to Forgo Life-Sustaining Treatment* 44 (1982).

For decades, medical, ethical, and religious leaders have drawn distinctions between suicide and the withdrawal of increasingly invasive treatment options. Pope Pius XII, for example, concluded in 1957 that physicians, consistent with a patient's wishes, could ethically withdraw a respirator under certain circumstances.[17] Pope

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[17] Pope Pius XII, *The Prolongation of Life, reprinted in* L'Osservator Romano, Nov. 25-26, 1957; *accord*, Sacred Congregation for the

Pius reasoned that, in such circumstances, death would result not from the removal of the respirator, but from the underlying condition or illness.

Significantly, against the accumulated wisdom of the medical, ethical, and religious communities, the Second Circuit failed to cite even one medical organization or text supporting its conclusion that withdrawing life support is the equivalent of assisted suicide. Instead, the court relied on a student law review note for this proposition.[18]

The consensus of the courts and the medical community is clear: Refusing medical treatment and ingesting toxic drugs are not the same. As this Court observed in *Cruzan*, the right to refuse medical treatment emerges from the right to bodily integrity and a corollary of the doctrine of informed consent (*i.e.*, the right to withhold consent). 497 U.S. at 269-70. Refusing life support, or

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Doctrine of the Faith, *Declaration on Euthanasia* 12 (Boston: Daughters of St. Paul 1980); *see also* Pope John Paul II, Encyclical Letter *Evangelium Vitae* ¶ 65 (March 25, 1995) ("[e]uthanasia must be distinguished from the decision to forgo so-called 'aggressive medical treatment' . . . . To forgo extraordinary or disproportionate means is not the equivalent of suicide or euthanasia").

[18] Pet. App. 30a (*citing* Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2028-31 (1992)). The court also cited Justice Scalia's concurrence in *Cruzan* for the "irrelevance of the action-inaction distinction." *See* 497 U.S. at 296-97. The court failed to recognize, however, that Justice Scalia's remark was made in the course of an opinion in which he urged that the Constitution does not provide any basis for disturbing legislative choices in this area. Although Justice Scalia saw the "action-inaction distinction" as an inadequate ground for overturning, under the Fourteenth Amendment, Missouri's decision not to permit the termination of life support for an unconscious patient, he readily acknowledged that the distinction "has some bearing upon the legislative judgment of what ought to be prevented as suicide . . . ." Justice Scalia thus endorsed a state legislature's prerogative to draw precisely the kind of distinction that the court of appeals in this case declared nonexistent.

indeed any medical treatment, thus involves the right to be free from bodily invasion and the right to consent to the medical treatment one receives. *Id.*[19] Such rights are not in any way implicated in a patient's request for toxic drugs.

B. States Have Legitimate Interests In Prohibiting Assisted Suicide.

Even if this Court were to determine that New York's statutory scheme classifies similarly situated groups, that scheme should still be upheld because it is rationally related to a legitimate government interest. Review under the rational basis standard "is the most relaxed and tolerant form of judicial scrutiny under the Equal Protection Clause." *Dallas v. Stanglin*, 490 U.S. 19, 26 (1989). In discussing rational basis scrutiny, this Court has stated that:

> the Fourteenth Amendment permits the States a wide scope of discretion in enacting laws which affect some groups of citizens differently than others. The constitutional safeguard is offended only if the classification rests on grounds wholly irrelevant to the achievement of the State's objective. State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their laws result in some inequality. A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it.

McGowan v. Maryland, 366 U.S. 420, 425-26 (1961).

Under rational basis scrutiny, therefore, legislation is presumed valid. *Cleburne*, 473 U.S. at 440 "[t]he general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute

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[19] *People v. Kevorkian*, 527 N.W.2d at 732 n.59 (patients "may refuse life-sustaining medical treatment because the treatment itself is a violation of bodily integrity").

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is rationally related to a legitimate state interest"). Only if such legislation is irrational will the Court invalidate it. *Kadrmas v. Dickinson Pub. Sch.*, 487 U.S. 450, 462 (1988) ("social and economic legislation . . . carries with it a presumption of rationality that can only be overcome by a clear showing of arbitrariness and irrationality").

The court below, however, stated that "[t]he general rule . . . is that state legislation carries a presumption of validity *if* the statutory classification is 'rationally related to a legitimate state interest.'" Pet. App. 21a (citation omitted; emphasis supplied). This precisely reverses the proper principles of equal protection review. The presumption of validity does not depend on the outcome of the constitutional scrutiny; rather it is the premise from which that scrutiny is to proceed. In any event, the court of appeals was wrong in concluding that states lack a legitimate governmental interest in prohibiting physician-assisted suicide.

The court of appeals' application of the rational basis standard appears to have been distorted by the court's improper consideration of quality of life issues. The court used those considerations to discount the State's important interest in the protection and preservation of human life. Pet. App. 31a ("[s]urely the state's interest lessens as the potential for life diminishes"). The Second Circuit's conclusion that government's interest in life must be adjusted to take into account an assessment—ultimately, a judicial assessment—of the quality of that life directly conflicts with this Court's holding in *Cruzan*:

> We think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . . .

497 U.S. at 282. As the Supreme Court of Missouri said, in the decision affirmed by this Court in *Cruzan*,

> the state's interest is not in quality of life. The state's interest is an unqualified interest in life. In striking the balance between a patient's right to refuse treatment or her right to privacy and the state's interest in life, we may not arbitrarily discount either side of the equation to reach a result which we find desirable.

Cruzan v. Harmon, 760 S.W.2d 408, 422 (Mo. 1988) (en banc).

Disregarding this point, the court of appeals ignored the State's interest in protecting all citizens and proceeded instead as if the only relevant state interest is one that varies with the subjective quality of life. The court thus implicitly denied that all lives remain under the full protection of the law. This simply cannot be reconciled with *Cruzan*. As Justice Scalia observed in his concurrence in that case,

> [t]he life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

497 U.S. at 295 (Scalia, J., concurring), *quoting Blackburn v. State*, 23 Ohio St. 146, 163 (1873).

The Second Circuit's opinion also conflicts with the Michigan Supreme Court's opinion in *People v. Kevorkian*. The Michigan court there observed that:

> [the same state] interests in the sancity of life that are represented by the criminal homicide laws *are threatened by one who expresses a willingness in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim.*

447 Mich. at 488 n.68, 527 N.W.2d at 736 n.68 (emphasis supplied). Although the court then went on to

question the severity of murder prosecutions of assisted suicide, the court viewed as undeniable the existence of some legitimate government interest in protecting all citizens.[21]

The fact that most states criminalize assisted suicide supports the conclusion that government has a legitimate interest in regulating such activity. At least forty-one States, Puerto Rico, and the Virgin Islands impose criminal penalties on those who assist another to commit suicide. The relevant statutes and decisions are listed in Appendix C. As Justice Scalia observed in *Cruzan*, "American law has always accorded the State the power to prevent, by force if necessary, suicide . . . ." 497 U.S. at 293 (Scalia, J., concurring). Indeed, all fifty States have involuntary commitment statutes seeking to prevent suicide through the confinement of those who pose a danger to themselves.[22] If the States constitutionally may confine someone who poses a suicide threat, then surely the States may prevent the same person from obtaining a physician's aid in carrying out the threat.

In his concurrence below, Judge Calabresi seems to suggest that government interests fade over time and that the New York legislature needs to take "affirmative step[s] reaffirming the prohibition." Pet. App. 44a. This is, to put it mildly, a dubious basis for constitutional adjudication. In any event, New York has done precisely what Judge Calabresi asks.

New York periodically calls together a task force to discuss bio-medical issues. Convened by the Governor, it

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[21] The New York legislature has opted to punish assisted suicide as manslaughter rather than murder. New York Penal Law § 125.15 (McKinney 1995).

[22] *People v. Kevorkian*, 447 Mich. 436, 479, 527 N.W.2d 714, 732 (1994) ("all states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of non-deadly force to thwart suicide attempts").

brings together legislative, legal, and ethical experts to re-examine the State's interest in various such issues. In one of its most recent sessions, the Task Force concluded that:

> [a]ssisted suicide would carry us into new terrain. . . . We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals . . . are likely to be extraordinary.

New York State Task Force on Life and the Law, *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* vii-viii (July 1987).

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX

APPENDIX A

The state courts of last resort that have distinguished between withdrawal of life support and assisted suicide include the following:

In re Fiori, 673 A.2d 905, 910 (Pa. 1996)
People v. Kevorkian, 447 Mich. 436, 472-73, 527 N.W.2d 714, 728-29 (1994), *cert. denied*, 115 S. Ct. 1795 (1995)
Thor v. Superior Court, 5 Cal. 4th 725, 742, 855 P.2d 375, 385, 21 Cal. Rptr. 2d 357, 367 (1993) (en banc)
DeGrella ex rel. Parrent v. Elston, 858 S.W.2d 698, 707 (Ky. 1993)
In re L.W., 167 Wis. 2d 53, 83, 482 N.W.2d 60, 71 (1992)
In re Doe, 411 Mass. 512, 522, 583 N.E.2d 1263, 1270, *cert. denied*, 503 U.S. 950 (1992)
In re Lawrence, 579 N.E.2d 32, 40 n.4 (Ind. 1991)
McKay v. Bergstedt, 106 Nev. 808, 823, 801 P.2d 617, 627 (1990)
In re Browning, 568 So. 2d 4, 14 (Fla. 1990)
Fosmire v. Nicoleau, 75 N.Y.2d 218, 227 n.2, 551 N.E.2d 77, 82 n.2, 551 N.Y.S.2d 876, 881 n.2 (1990)
State v. McAfee, 259 Ga. 579, 580, 385 S.E.2d 651, 652 (1989)
In re Estate of Longeway, 133 Ill. 2d 33, 41, 549 N.E.2d 292, 296 (1989)
McConnell v. Beverly Enters., 209 Conn. 692, 710, 553 A.2d 596, 605 (1989)
In re Grant, 109 Wash. 2d 545, 563-64, 747 P.2d 445, 454-55 (1987), *modified on other grounds*, 757 P.2d 534 (Wash. 1988)
In re Gardner, 534 A.2d 947, 955-56 (Me. 1987)
Rasmussen v. Fleming, 154 Ariz. 207, 218, 741 P.2d 674, 685 (1987)

In re Conroy, 98 N.J. 321, 350-51, 486 A.2d 1209, 1224 (1985)
In re P.V.W., 424 So. 2d 1015, 1022 (La. 1982)

A number of state lower courts also draw a distinction between suicide and withdrawing life support. *See, e.g., Donaldson v. Lundgren*, 2 Cal. App. 4th 1614, 1621, 4 Cal. Rptr. 2d 59, 62 (1992); *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 1144-45, 225 Cal. Rptr. 297, 306 (1986); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220, 225 (1984); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1012, 195 Cal. Rptr. 484, 487 (1983); *Foody v. Manchester Mem. Hosp.*, 40 Conn. Supp. 127, 137, 482 A.2d 713, 720 (1984); *In he Severns*, 425 A.2d 156, 158 (Del. Ch. 1980); *Satz v. Perlmutter*, 362 So.2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980); *In re Rosebush*, 195 Mich. App. 675, 681 n.2, 491 N.W.2d 633, 636 n.2 (1992); *In re Eichner*, 102 Misc. 2d 184, 205, 423 N.Y.S.2d 580, 594 (Sup. Ct. 1979), *aff'd as modified sub nom. Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (App. Div. 1980), *aff'd as modified sub nom. In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *Leach v. Akron General Med. Ctr.*, 68 Ohio Misc. 1, 10, 426 N.E.2d 809, 815 (Ct. Com. Pl. 1980); *In re Fiori*, 438 Pa. Super. 610, 619, 652 A.2d 1350, 1354 (1995) (en banc), *aff'd*, 673 A.2d 905 (Pa. 1996).

APPENDIX B

The state living will statutes that distinguish between withdrawal of life support and assisted suicide include the following:

Ala. Code § 22-8A-10 (1995)
Alaska Stat. § 18.12.080(f) (1995)
Ariz. Rev. Stat. Ann. § 36-3210 (1995)
Ark. Code Ann. § 20-17-210(g) (Michie 1995)
Cal. Health & Safety Code § 7191.5(g) (West 1995)
Colo. Rev. Stat. Ann. § 15-18-112(1) (West 1995)
Conn. Gen. Stat. Ann. § 19a-575 (West 1995)
Del. Code Ann. tit. 16, § 2507 (1995)
D.C. Code Ann. § 6-2430 (1995)
D.C. Code Ann. § 21-2212 (1995) (durable power of attorney for health care)
Fla. Stat. Ann. § 765.309(1) (West 1995)
Ga. Code Ann. § 31-32-9 (1995)
Ga. Code Ann. § 31-36-2 (1995) (durable power of attorney for health care)
Haw. Rev. Stat. § 327D-13 (1995)
Idaho Code § 39-161(1) (1995) (do not resuscitate orders)
Ill. Comp. Stat. ch. 755, para. 35/9(f) (Smith-Hurd 1995)
Ill. Comp. Stat. ch. 755, para. 40/50 (Smith-Hurd 1995) (durable power of attorney for health care)
Ind. Code Ann. § 16-36-4-19 (West 1995)
Ind. Code Ann. § 16-36-1-13 (West 1995) (durable power of attorney for health care)
Iowa Code Ann. § 144A.11.6 (West 1995)
Iowa Code Ann. § 144B.12.2 (West 1995) (durable power of attorney for health care)
Kan. Stat. Ann. § 65-28,109 (1995)
Ky. Rev. Stat. Ann. § 311.637 (Michie/Bobs-Merrill 1995)
La. Rev. Stat. Ann. § 1299.58.10 (West 1995)
Me. Rev. Stat. Ann. tit. 18-A, § 5-813 (West 1995)

Md. Code Ann., Health-Gen. § 5-611 (1995)
Mass. Gen. Laws Ann. ch. 201D, § 12 (West 1995) (durable power of attorney for health care)
Mich. Comp. Laws Ann. § 700.496(20) (West 1995) (durable power of attorney for health care)
Minn. Stat. Ann. § 145B.14 (West 1995)
Miss. Code Ann. § 41-41-117(2) (1993)
Mo. Ann. Stat. § 459.059(5) (Vernon 1995)
Mont. Code Ann. § 50-9-205(7) (1995)
Neb. Rev. Stat. § 20-412(7) (1995)
Nev. Rev. Stat. § 449.670(2) (1993)
N.H. Rev. Stat. Ann. § 137-H:10(II) (1995)
N.J. Stat. Ann. § 26:2H-54(e) (West 1995)
N.M. Stat. Ann. § 24-7-8 (Michie 1996)
N.Y. Pub. Health Law § 2989(3) (McKinney 1995) (durable power of attorney for health care)
N.C. Gen. Stat. § 90-320(b) (1995)
N.D. Cent. Code § 23-06.4-01 (1995)
N.D. Cent. Code § 23-06.5-01 (1995) (durable power of attorney for health care)
Ohio Rev. Code Ann. § 2133.12(d) (Baldwin 1996)
Okla. Stat. Ann. tit. 63, § 3101.12(g) (West 1995)
Or. Rev. Stat. § 127.570 (1995)
20 Pa. Cons. Stat. Ann. § 5402(b) (1995)
R.I. Gen. Laws § 23-4.11-10(f) (1955)
R.I. Gen. Laws § 23-4.10-9(f) (1995) (durable power of attorney for health care)
S.C. Code Ann. § 44-77-130 (Law. Co-op. 1993)
S.D. Codified Laws Ann. § 34-12D-20 (1996)
Tenn. Code Ann. § 32-11-110 (1995)
Tex. Health & Safety Code Ann. § 672.020 (West 1995)
Utah Code Ann. § 75-2-1118 (1995)
Vt. Stat. Ann. tit. 18, § 5260 (1995)
Va. Code Ann. § 54.1-2990 (Michie 1995)
Wash. Rev. Code Ann. § 70.122.100 (West 1995)
W. Va. Code § 16-30-10 (1995)

Wis. Stat. Ann. § 154.11(6) (West 1995)
Wyo. Stat. § 35-22-109 (1995)
Wyo. Stat. § 3-5-211 (1995) (durable power of attorney for health care).

APPENDIX C

The following thirty-seven states and territories have statutes that impose criminal penalties for assisting a suicide:

Alaska Stat. § 11.41.120(a)(2) (1995)
Ariz. Rev. Stat. Ann § 13-1103(A)(3) (1995)
Ark. Code Ann. § 5-10-104(a)(2) (Michie 1995)
Cal. Penal Code § 401 (West 1995)
Colo. Rev. Stat. § 18-3-104(1)(b) (West 1995)
Conn. Gen. Stat. Ann. § 53a-56(a)(2) (West 1995)
Del. Code Ann. tit. 11, § 645 (1995)
Fla. Stat. Ann. § 782.08 (West 1995)
Ga. Code Ann. § 16-5-5(b) (1995)
Haw. Rev. Stat. § 707-702 (1995)
Ill. Comp. Stat. ch. 720, para. 5/12-31 (Smith Hurd 1995)
Ind. Code Ann. § 35-42-1-2.5(b) (West 1995)
Iowa Code Ann. §§ 707A.2, 707A.3 (1996)
Kan. Stat. Ann. § 21-3406 (1995)
Ky. Rev. Stat. Ann. § 216.302 (Baldwin 1995)
La. Rev. Stat. Ann. § 14:32.12 (West 1995)
Me. Rev. Stat. Ann. tit. 17-A, § 204 (West 1995)
Mich. Comp. Laws Ann. § 752.1027 (West 1995)
Minn. Stat. Ann. § 609.215 (West 1995)
Miss. Code Ann. § 97-3-49 (1993)
Mo. Ann. Stat. § 565.023(1)(2) (Vernon 1995)
Mont. Code Ann. § 45-5-105 (1993)
Neb. Rev. Stat. § 28-307 (1995)
N.H. Rev. Stat. Ann. § 630:4 (1995)
N.J. Stat. Ann. § 2C:11-6 (West 1995)
N.M. Stat. Ann. § 30-2-4 (Michie 1995)
N.Y. Penal Law § 120.30 (McKinney 1995)
N.Y. Penal Law § 125.15 (McKinney 1995)
N.D. Cent. Code § 12.1-16-04 (1955)
Okla. Stat. Ann. tit. 21, § 813 (West 1995)
Or. Rev. Stat. § 163.125(b) (1995)

18 Pa. Cons. Stat. Ann. § 2505 (1995)
P.R. Laws Ann. tit. 33, § 4009 (1990)
S.D. Codified Laws Ann. § 22-16-37 (1996)
Tenn. Code Ann. § 39-13-216 (1995)
Tex. Penal Code Ann. § 22.08 (West 1995)
V.I. Code Ann. tit. 14, § 2141 (1994)
Wash. Rev. Code Ann. § 9A.36.060 (West 1995)
Wis. Stat. Ann. § 940.12(West 1995).

The following two states have negligent homicide statutes broad enough to penalize assisting a suicide: Ala. Code § 13A-6-4 (1995); and Wyo. Stat. § 6-2-107 (1995).

The following five states have case law authorizing the imposition of criminal penalties for assisting a suicide: *McMahan v. State*, 168 Ala. 70, 53 So. 89 (1910); *Commonwealth v. Bowen*, 13 Mass. 356 (1816); *State v. Willis*, 255 N.C. 473, 121 S.E.2d 854 (1961); *Blackburn v. State*, 23 Ohio St. 146 (1872); and *State v. Jones*, 86 S.C. 17, 67 S.E. 160 (1910).

Supreme Court, U.S.
FILED
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No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM 1995

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

RESPONDENTS' OPPOSITION TO MOTIONS TO FILE BRIEFS AMICUS CURIAE

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RESPONDENTS' OPPOSITION TO MOTIONS TO FILE BRIEFS AMICUS CURIAE

Respondents oppose the motions for leave to file briefs amicus curiae submitted by the United States Catholic Conference, et al., the Catholic Medical Association, Agudeth Israel of America, and Seven Present and Former Commissioners of the Commission on Civil Rights and a Former Chairman of the Equal Employment Opportunity Commission on the grounds that these amici fail to meet the directives of Supreme Court Rule 37.1.

Rule 37.1 makes plain that amicus curiae briefs are appropriate only when they bring relevant matter to the attention of the Court that has not already been brought to its attention by the parties. The briefs proposed by amici do not serve this purpose and therefore burden the Court. *See id.* Accordingly, after amici advised respondents of the arguments they intended to make to the Court, respondents denied consent to amici participation at this stage of proceedings. When the consent of all parties has not been obtained at the certiorari stage, a motion for leave to file an amicus curiae brief is disfavored. Supreme Court Rule 37.2(b).

Petitioners have already addressed at length the issues briefed by amici. For instance, several amici restate petitioners' position that the decision below conflicts with other courts in a manner that warrants this Court's review. Each of the amicus briefs also repeats views fully discussed by petitioners regarding purported distinctions between alternative methods of hastening death. This redundancy is burdensome to the Court and is disfavored by the rules governing amicus participation.

The amici moving to participate at this stage of proceedings are, with a single exception, religious organizations. The questions regarding end-of-life decisions implicated in this case are clearly of interest to religious organizations; so too are questions relating to the beginning of life. However, religious teachings cannot be permitted to affect the decisions of this Court. As stated in *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2806 (1992), the Court's "obligation is to define the liberty of all, not mandate [its] own moral code."

For the foregoing reasons, respondents submit that the motions for leave to file briefs amicus curiae should be denied.

Respectfully Submitted,

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No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM 1995

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

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v.

TIMOTHY E. QUILL, M.D.; SAMUEL KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

SUPPLEMENTAL BRIEF OF RESPONDENTS IN RESPONSE TO BRIEF AMICI CURIAE OF SEVERAL STATES

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Pursuant to Supreme Court Rule 15.7, Respondents submit this supplemental brief in response to the brief submitted by several states as amici curiae. *Brief of Amici Curiae States of California, et al.*[1]

I. THE AMICUS BRIEF FAILS TO MEET THE STANDARD FOR AN AMICUS SUBMITTAL

The amicus brief fails to meet the standard set forth in Supreme Court Rule 37.1, which requires that amicus briefs bring to the attention of the Court relevant matter that has not already been brought to its attention by the parties. Petitioners have already addressed at length the issues briefed by these amici. Respondents have addressed each argument in their opposition brief and will not restate these arguments here, but will simply respond to two points raised by amici.

II. AMICI'S FEDERALISM ARGUMENT IS MISGUIDED

Amici contend that the decision below offends principles of federalism. Amici Br. at 17. This argument is misguided. Where constitutional rights are infringed by state legislative action, it is the duty of the judiciary to intervene and protect such rights.[2] *See, e.g., Schweiker v. Wilson*, 450 U.S. 221, 230 (1981) (where the democratic process impinges on constitutional rights, "the judiciary then has a duty to intervene in the democratic process"); *Marshall Field & Co. v.*

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[1] The amicus brief presents the views of less than one-third of the states. The vast majority of states do not urge that review be granted.

[2] A recent, cogent refutation of the flawed federalism argument advanced by the states is set forth in R. Dworkin's *Freedom's Law* (Harvard University Press 1996).

Clark, 143 U.S. 649, 670 (1892) (recognizing "duty of this court, from the performance of which it may not shrink, to give full effect to the provisions of the Constitution"); *Marbury v. Madison*, 5 U.S. (1 Cranch) 137 (1803).

Moreover, rather than usurping the states' role, the decision below respects the proper role of the state in regulating physician assisted dying. The Second Circuit's analysis relies on basic equal protection principles in ruling that New York, having passed legislation permitting physician assisted death in a variety of circumstances, cannot deny physician assistance in the narrow circumstances presented here. That is, having granted the right to medically assisted death to its dying citizens, New York cannot constitutionally deny some dying citizens an equivalent exercise of that right.

States that have granted and continue to grant the right to physician assistance in dying are free to, and indeed should, develop regulatory schemes addressing physician assisted death. Current state laws pertaining to living wills and health proxies begin to do just that. Far from ignoring states' autonomy in this area, the decision below explicitly acknowledges that states will continue to play an important role in regulating physician assisted dying. *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996).

States cannot reasonably claim ignorance with regard to what further regulatory schemes might be appropriate. Proposed schemes abound in both legal and medical literature. *E.g.*, Charles Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harvard J. on Legis. 1 (Winter 1996); Timothy E. Quill, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 N. Eng. J. Med. 1380 (1992); N.Y. A.B. 6333, 219th Leg., 2d Sess. (1995).

III. STATE POLICE POWER DOES NOT TRUMP THE EQUAL PROTECTION CLAUSE

Contrary to amici's argument, the police power of states does not trump states' obligation to remain within the bounds of the Equal Protection Clause. Here, the police power does not extend to disallowing a dignified death to an arbitrary subgroup of dying citizens.

Historically, in every case in which a state has sought to constrain equal rights and liberties of individuals, the state has defended its action as within its police power. This was true where individuals sought desegregation of schools, *Brown v. Board of Education*, 347 U.S. 483 (1954), where individuals desired access to contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965), where individuals of different races sought to marry, *Loving v. Virginia*, 385 U.S. 986 (1966), where women sought access to abortion services, *Roe v. Wade*, 410 U.S. 113 (1973), and where families sought to arrange the composition of their homes, *Moore v. City of East Cleveland*, 431 U.S. 494 (1977). The state's argument in support of its power to act in the context of this case is far weaker than in many of the cases where this Court has determined that the police power is not as expansive as the state urged. As the Court below recognized, the proper scope of state action is limited to reasonable regulation designed to protect legitimate state interests.

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No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

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PETITION FOR CERTIORARI FILED MAY 16, 1996
CERTIORARI GRANTED OCTOBER 1, 1996

TABLE OF CONTENTS

PAGE

Chronological List of Relevant Docket Entries JA1

Order Granting Writ of Certiorari, filed dated October 1, 1996 ..... JA19

Complaint for Declaratory Judgment and Injunctive Relief, filed 07/20/94 ..... JA21

Answer and Affirmative Defenses to Complaint by Defendant G. Oliver Koppell, filed 08/23/94..... JA30

Order to Show Cause, filed 09/16/94 ..... JA34

Affidavit of Carla A. Kerr, Esq. in Support of Plaintiff's Motion for Preliminary Injunction, filed 09/16/94 ..... JA37

Declaration of Timothy E. Quill, M.D., filed 09/16/94..... JA42

Declaration of Samuel C. Klagsbrun, M.D., filed 09/16/94..... JA68

Declaration of Howard A. Grossman, M.D., filed 09/16/94..... JA84

Declaration of William A. Barth, filed 09/16/94 ..... JA96

Declaration of George A. Kingsley, filed 09/16/94.... JA99

Affidavit of Carla A. Kerr, Esq. with respect to Jane Doe Affidavit, filed 09/16/94 ..... JA103

PAGE

Excerpts from Defendant Attorney General G. Oliver Koppell's Memorandum of Law in Opposition to Motion for a Preliminary Injunction, filed 10/11/94, pages 6-7 ..... JA110

Notice of Cross-Motion by Defendant G. Oliver Koppell for Judgment on Pleadings, filed 10/11/94 ..... JA113

Supplemental Declaration of Timothy E. Quill, M.D., filed 10/14/94 ..... JA115

Supplemental Declaration of Samuel C. Klagsbrun, M.D., filed 10/14/94 ..... JA120

Supplemental Declaration of Howard A. Grossman, M.D., filed 10/14/94 ..... JA122

Declaration of Jack Froom, M.D., filed 10/14/94..... JA124

Declaration of Minna Barrett in Support of Plaintiffs' Motion to Add Governor Mario M. Cuomo as Defendant, filed 10/14/94 ..... JA154

Amended Complaint for Declaratory Judgment and Injunctive Relief, filed 10/14/94..... JA157

Order Granting Leave to Amend Complaint, dated 10/17/94 ..... JA165

Order to Show Cause, filed 10/20/94 ..... JA166

Second Amended Complaint for Declaratory Judgment and Injunctive Relief, filed 10/20/94 ..... JA168

PAGE

Answer to Second Amended Complaint by Defendants G. Oliver Koppell and Mario M. Cuomo, filed 10/28/94 ..... JA176

Excerpts from District Attorney Robert M. Morgenthau's Memorandum of Law in Opposition to Motion for a Preliminary Injunction, filed 10/30/94, pages 1-2 ..... JA179

Affidavit of Michael S. Popkin, Esq. on Behalf of Defendant Mario M. Cuomo in Opposition to Plaintiffs' Motion for Preliminary Injunction and in Support of Cross-Motion for Judgment on the Pleadings, filed 11/01/94 ..... JA182

Answer to Second Amended Complaint, by Defendant Robert M. Morgenthau, filed 11/09/94..... JA185

Second Supplemental Declaration of Timothy E. Quill, M.D., filed 11/28/94..... JA189

Second Supplemental Declaration of Samuel C. Klagsbrun, M.D., filed 11/28/94 ..... JA191

Second Supplemental Declaration of Howard A. Grossman, M.D., filed 11/28/94 ..... JA193

Opinion of the District Court JA195

Judgment, entered 12/21/94 ..... JA211

Notice of Appeal, filed 01/03/95..... JA213

Opinion of Second Circuit JA215

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

Case No. 94 Civ. 5321 (TPG)

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

7/20/94	1	COMPLAINT filed; Summons issued and Notice pursuant to 28 U.S.C. 636(c); FILING FEE $120 RECEIPT # 220299 (sc) [Entry date 07/25/94]
7/20/94	2	Rule 9 certificate filed by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth (sc) [Entry date 07/25/94]

7/20/94	3	Case Information Statement Addendum and Case Designation to a Magistrate Judge filed. Purs. to statement, it is suggested that the case be classified as expedited. Case is designated to Magistrate Judge Bernikow. (sc) [Entry date 07/25/94]
8/22/94	4	STIPULATION and ORDER, reset answer due for 8/22/94 for C. Oliver Koppell (signed by Chief Judge Thomas P. Griesa). (gb) [Entry date 08/23/94]
8/23/94	5	ANSWER to Complaint by G. Oliver Koppell (Attorney Susan L. Watson), by attorney Susan L. Watson for defendant G. Oliver Koppell. (kg) [Entry date 08/25/94]
9/16/94	6	DECLARATION of Howard A. Grossman Re: . . . his competency to testify in above case. (djc)
9/16/94	7	DECLARATION of George A. Kingsley Re: . . . his competency to testify in above case. (djc)
9/16/94	8	DECLARATION of William A. Barth Re: . . . his competency to testify in above entitled case. . . (djc)
9/16/94	9	MEMORANDUM OF LAW by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth in support of Plaintiffs' Motion for a Preliminary Injunction. (djc)
9/16/94	10	DECLARATION of Timothy E. Quill Re: . . . his competency to testify. . . . (djc)
9/16/94	11	DECLARATION of Samuel C. Klagsbrun Re: . . . his competency to testify. . . . (djc)

9/16/94	12	AFFIDAVIT in support of Carla A. Kerr by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: of Motion for a Preliminary Injunction. (djc)
9/16/94	—	ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 10:00 9/27/94 . . . to show cause why a preliminary injunction should not be issued. . . IT IS FURTHER ORDERED, that no undertaking be filed by the plaintiffs since it does not appear that any damages may be suffered or. . . . IT IS FURTHER ORDERED, that service of this order to show cause together with a copy of the papers submitted in support hereof upon defendant on or before September 16, 1994 at 1:00 p.m. shall be deemed sufficient service as to defendant; IT IS FURTHER ORDERED, that defendant shall serve, by hand, any affidavits, exhibits and or memorandum of law in opposition upon plaintiffs attorneys on or before September 23, 1994 at 5:00 p.m.; IT IS FURTHER ORDERED, that plaintiffs shall serve any reply affidavits, exhibits and or memoranda upon defendant on or before September 26, 1994. (Signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc)
9/16/94	13	AFFIDAVIT of Carla A. Kerr by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: . . . for the purpose of providing the Court with a redacted copy

of the Declaration of Jane Doe, attached as Exhibit A. (djc) [Entry date 09/19/94]

9/16/94 14 NOTICE OF MOTION by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William Barth for Kathryn L. Tucker to appear pro hac vice solely for purposes of this litigation, Return date 9/27/94 (djc) [Entry date 09/19/94] [Edit date 09/19/94]

9/16/94 14 AFFIDAVIT in support of Carla A. Kerr by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: [14-1] motion for Kathryn L. Tucker to appear pro hac vice for plaintiffs solely for purposes of this litigation. (djc) [Entry date 09/19/94]

9/16/94 14 AFFIDAVIT in support of Kathryn L. Tucker by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth Re: [14-1] motion for Kathryn L. Tucker to appear pro hac vice for plaintiffs for the purposes of this action. (djc) [Entry date 09/19/94]

9/16/94 — ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 10:00 9/27/94 (signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc) [Entry date 09/19/94]

9/16/94 15 ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 10:00 9/27/94 . . . to show why a preliminary injunction should not be issued. . . . (signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc) [Entry date 09/20/94]

10/6/94 16 ORDER, that the New York State Catholic Conference is granted permission to file a brief as amicus curiae in the above-captioned matter. SO ORDERED. (signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc)

10/11/94 17 AFFIDAVIT of Doris J. Barnes Re., served 2 copies of briefs of N.Y. State Catholic Conference on Michael S. Popkin on 10/6/94, Carla A. Kerr on 10/6/94, Kathryn L. Tucker on 10/6/94, by mail. (gb)

10/11/94 18 NOTICE OF CROSS-MOTION by C. Oliver Koppell for judgment on the pleadings. . . . , Return date 10/14/94 (djc)

10/11/94 19 MEMORANDUM OF LAW by C. Oliver Koppell in opposition to Motion for a Preliminary Injunction (djc)

10/11/94 19 MEMORANDUM OF LAW by C. Oliver Koppell in support of [18-1] cross motion for judgment on the pleadings. . . . (djc)

10/14/94 20 REPLY MEMORANDUM by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth in support of Motion for Preliminary Injunction. (djc) [Entry date 10/17/94]

10/14/94 21 DECLARATION in support by Howard A. Grossman for preliminary injunction. (djc) [Entry date 10/17/94]

10/14/94 22 DECLARATION of Minna Barrett in support of plaintiffs' motion to add Governor Mario M.

Cuomo as defendant herein. (djc) [Entry date 10/17/94]

10/14/94 23 DECLARATION of support by Samuel C. Klagsbrun of plaintiffs' motion for a preliminary injunction. . . (djc) [Entry date 10/17/94]

10/14/94 24 SUPPLEMENTAL DECLARATION of support by Timothy E. Quill of Plaintiffs' motion for a preliminary injunction. . . (djc) [Entry date 10/17/94]

10/14/94 25 DECLARATION of Jack Froom, M.D. Re: his competency to testify. . . . (djc) [Entry date 10/17/94]

10/14/94 26 AMENDED COMPLAINT by Timothy E. Quill, Samuel G. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth, (Answer due 10/27/94 for C. Oliver Koppell) amending [1-1] complaint against George A. Kingsley, Mario M. Cuomo; Summons issued. (gb) [Entry date 10/17/94]

10/18/94 27 Order classifying case. Purs. to the Civil Justice Expense and Delay Reduction Plan, this case has been determined to be standard. .NO MEDIATION. (signed by Chief Judge Thomas P. Griesa) (djc) [Entry date 10/19/94]

10/20/94 28 ORDER TO SHOW CAUSE by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth. Show Cause Hearing set for 5:00 11/1/94 to show cause by serving, by hand, any supplemental papers in opposition . . why a preliminary injunction should not issue pursuant to Rule 65. . . .

(signed by Chief Judge Thomas P. Griesa); Copies mailed. (djc) [Entry date 10/21/94]

10/20/94 29 SECOND AMENDED COMPLAINT by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, Jane Doe, George A. Kingsley, William A. Barth (Answer due 11/9/94 for Mario M. Cuomo, for C. Oliver Koppell amending [26-1] amended complaint against Robert M. Morganthau; Summons issued. (djc) [Entry date 10/26/94]

10/28/94 32 ANSWER to Complaint by C. Oliver Koppell, Mario M. Cuomo (Attorney Michael S. Popkin); Firm of: G. Oliver Koppell by attorney Michael S. Popkin for defendant C. Oliver Koppell. (djc) [Entry date 11/01/94]

10/31/94 30 MEMORANDUM OF LAW by Robert M. Morganthau in opposition to Motion for a Preliminary Injunction. (djc) [Entry date 11/01/94]

11/1/94 31 AFFIDAVIT in opposition of Michael S. Popkin Re: to Plaintiffs' Motion for Preliminary Injunction. (djc)

11/1/94 31 AFFIDAVIT in support of Michael S. Popkin Re: [18-1] cross motion for judgment on the pleadings. . . . (djc)

11/3/94 33 RETURN OF SERVICE of Summons and Complaint executed as to Mario M. Cuomo by upon defendant on 10/12/94 Answer due on 11/1/94 for Mario M. Cuomo (djc) [Entry date 11/08/94]

11/3/94 34 RETURN OF SERVICE of Summons and Complaint executed as to Robert M. Morganthau upon defendant on 10/20/94 Answer due on

11/9/94 for Robert M. Morganthau (djc) [Entry date 11/08/94]

11/4/94 36 ORDER, that leave to so amend is granted. Plaintiffs may file and serve such an amended complaint in this matter. (signed by Chief Judge Thomas P. Griesa); Copies mailed (djc) [Entry date 11/16/94]

11/9/94 35 ANSWER by Robert M. Morganthau (Attorney James M. McGuire) to second amended complaint; Firm of: District Attorney by attorney James M. McGuire for defendant Robert M. (djc)

11/28/94 37 SECOND SUPPLEMENTAL DECLARATION in support by Samuel C. Klagsbrun of Plaintiff's motion for a preliminary injunction. (djc) [Entry date 11/29/94]

11/28/94 38 SECOND SUPPLEMENTAL DECLARATION in support by Timothy E. Quill of Plaintiffs' motion for a preliminary injunction. (djc) [Entry date 11/29/94]

11/28/94 39 SECOND SUPPLEMENTAL DECLARATION in support by Howard A. Grossman of Plaintiffs' motion for a preliminary injunction. (djc) [Entry date 11/29/94]

12/2/94 40 AFFIDAVIT of Jerome J. De Cosse, M.D. in support of argument of legal center for defense of life appearing as amicus in support of defts.. (gb)

12/2/94 41 AFFIDAVIT of Richard Gallagher, M.D. in support of Richard Gallagher Re: in support of argument of legal center of defense of life appearing as amicus in support of defts.. (gb)

12/2/94 42 AFFIDAVIT of Joseph George in support of the amicus curiae Legal Center for the defense of life in opposition to pltffs' motion for a preliminary inj. Joseph George M.D. Re: (gb)

12/2/94 43 AFFIDAVIT of Kenneth Prager M.D. Re: in support of the Amicus Curia of the Legal Center for Defense of Life in opposition to pltffs' motion for a preliminary injunction against the enforcement of those portions of sections 125.15(3) and 120.30 of the N.Y. Penal Law which prohibit physician-assisted suicide. . (gb)

12/16/94 44 MEMORANDUM OPINION # 74086 . . . . Plaintiffs' motion for a preliminary injunction is denied.. Defts' motion to dismiss, treated as a motion for summary judgment, is granted, and the action is dismissed. . . SO ORDERED. . (Signed by Chief Judge Thomas P. Griesa); Copies mailed. (kk) [Entry date 12/21/94]

12/21/94 45 JUDGMENT; ORDERED, Adjudged and Decreed: that plaintiffs' motion for a preliminary injunction be and it is hereby denied, and it is further, ORDERED, that defendants' motion to dismiss, treated as a motion for summary judgment, be and it is hereby granted, and it is further ORDERED, that the action be and it is hereby dismissed for the reasons stated in the Court's Opinion, dated December 16, 1994 (signed by Chief Judge Thomas P. Griesa); Mailed copies and notice of right to appeal. EOD - 12/21/94 (djc)

12/27/94	46	Filed Memo Endorsement on letter dated 11/4/94, for leave to file amicus curiae memo of law by the Legal Center for the Defense of Life (signed by Chief Judge Thomas P. Griesa). (cd) [Entry date 01/03/95]
1/3/95	47	NOTICE OF APPEAL by Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman; from [45-1] judgment order. Copies of notice of appeal mailed to Attorney(s) of Record: James M. McGuire, Michael S. Popkin. (em) [Entry date 01/05/95]
1/5/95	—	Notice of Appeal and certified copy of docket to USCA: [47-1] appeal by Howard A. Grossman, Samuel C. Klagsbrun, Timothy E. Quill; Copy of notice of appeal sent to District Judge. (em)
2/7/95	48	Transcript of record of proceedings filed for dates of 10/19/94 (rg)
3/2/95	49	Transcript of record of proceedings filed for dates of 10/19/94 (rg)
3/15/95	50	Notice that the record on appeal has been certified and transmitted to the U.S. Court of Appeals: [47-1] appeal by Howard A. Grossman, Samuel C. Klagsbrun, Timothy E. Quill. (rg) [Entry date 03/17/95]
4/26/96	51	STIPULATION and ORDER, extending time to claim attys fees up to and including the 30th day after entry of final judgment in the SDNY. (Signed by Chief Judge Thomas P. Griesa). (lam) [Entry date 04/29/96]

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

95-7028

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants-Appellees,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs-Appellants.

1/6/95	Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman duplicate Form C filed, with proof of service. [95-7028] (cv71)
1/6/95	Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman duplicate Form D filed, with proof of service. [95-7028] (cv71)
1/11/95	Copy of district court docket entries and notice of appeal on behalf of Appellants Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D., and Howard A. Grossman, M.D., filed. [95-7028] Form C and D due on 1/13/95. (cv70)

1/11/95 Copy of receipt re: payment of docketing fee filed on behalf of Appellants Timothy E. Quill, M.D., ET AL. receipt. #:229853. [95-7028] (cv70)

1/13/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman Form C filed, with proof of service. [95-7028] Form C deadline satisfied. (cv71)

1/13/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman Form D filed, with proof of service. [95-7028] Form D deadline satisfied. (cv71)

1/19/95 Scheduling order #1 filed. Record on appeal due on 2/13/95. Appellant's brief and appendix due on 2/21/95. Appellee's brief due on 3/23/95. Argument as early as week of 4/17/95. (Pre-Argument Conference scheduled for February 2, 1995 at 3:00 P.M.). (cv71)

1/27/95 Letter received from Carla A. Kerr requesting permission for two attorneys to argue appeal. (Ms. Kerr has been notified that a motion is required.) (cv71)

2/2/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman motion to allow permission to divide the time allocated for oral argument between the two lawyers who argued the case below, FILED (w/pfs). [614870-1] (cv71)

2/2/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman AMENDED Form C, filed, with proof of service. (cv71)

2/13/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman motion to extend time to file brief and to file the motion out time FILED (w/pfs). [616849-1] (cv71)

2/16/95 Order FILED GRANTING motion for extended time [616849-1] by Appellant Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman, endorsed on motion form dated 2/13/95. Extended appellant's brief due date is 3/3/95. Extended appellee's brief due date is 4/3/95. Extended argument week as early as 4/24/95. [By: SAB] (cv71)

3/3/95 Notice of appearance form on behalf of Carla A. Kerr, Esq., received. (Orig. to Calendar) (in01)

3/3/95 New party added: Amicus LAMBDA Legal Defense and Education Fund, Inc., National Association of People with AIDS, the Unitarian Universalist Association, Americans for Death with Dignity, Death with Dignity Education Center, the Gray Panthers Project Fund, the Hemlock Society, and Minna Barrett. (cv73)

3/3/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman brief RECEIVED. Problem: no roa index filed. (cv71)

3/3/95 Joint appendix received. Number of volumes: 1. Problem: no roa index filed. (cv71)

3/3/95 Stipulation from Appellants Timothy E. Quill, et al. and Appellee Robert M. Morgenthau, where parties agree that Lambda Legal Defense and Education Fund, Inc., National Association of People with AIDS, the Unitarian Universalist Association, Americans for Death with Dignity, Death with Dignity Education Center, the Gray Panthers Project Fund, the Hemlock Society, and Minna Barrett may file an amici curiae brief, filed. (cv71)

3/3/95 Amicus Curiae Lambda Legal Defense, Nat'l Assoc. People, Unitarian Universali, Americans for Death, Death with Dignity, Gray Panthers Pro-

ject, Hemlock Society, and Minna Barrett brief filed with proof of service. (cv71)

3/15/95 Record on appeal index in lieu of record received. Problem: late. (cv71)

3/16/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman motion to file late record index FILED (w/pfs). [628567-1] (cv71)

3/20/95 Order FILED GRANTING motion to file late [628567-1] by Appellant Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman, endorsed on motion form dated 3/16/95. [By: SAB] (cv71)

3/20/95 Record on appeal index in lieu of record filed. (ag41)

3/20/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman brief FILED with proof of service. (ag41)

3/20/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman joint appendix filed w/pfs. (ag41)

4/3/95 Letters of consent, for the United States Catholic Conference and the New York State Catholic Conference to file an amicus curiae Brief in support of appellees, received. (cv71)

4/3/95 New party added: The United States Catholic Conference and New York State Catholic Conference. (cv71)

4/3/95 Letters received from parties consenting to the filing of an amicus brief by the National Right to Life Committee, Inc. in support of Defendants-Appellees. (cv71)

4/3/95 New party added: The National Right to Life Committee, Inc. (cv71)

4/3/95 Amicus Curiae Nat. Right to Life brief received. Problem: Incorrect caption and docket #. (cv71)

4/4/95 Amicus Curiae Nat. Right to Life brief filed with proof of service. (cv71)

4/4/95 Appellees Dennis C. Vacco, and George E. Pataki brief filed with proof of service. (cv71)

4/5/95 Appellee Robert M. Morgenthau brief filed with proof of service. [SERVICE EFFECTED BY MAIL ON APRIL 3, 1995] (cv71)

4/6/95 Amicus Curiae U.S. Catholic Confer, and NYS Catholic Conference 28(J) letter received with a copy of a Notre Dame. Law Review article which was cited in their amicus brief. (cv71)

4/6/95 Movant Members NYS Legislature brief received. Problem: Motion is missing T-1080. (cv71)

4/7/95 New party added: The New York State Right to Life Committee, Inc. (cv71)

4/7/95 Movant NYS Right to Life brief received. Problem: Motion pending and incorrect color. (cv71)

4/7/95 Movant NYS Right to Life motion to file brief as amicus curiae FILED (W/pfs). [637710-1] (cv71)

4/11/95 Order FILED GRANTING motion to file brief as amicus curiae [637710-1] by Movant NYS Right to Life, endorsed on motion form dated 4/7/95. (cv71)

4/12/95 Amicus Curiae NYS Right to Life brief filed with proof of service. (cv71)

4/12/95 Letter received from Claudia L. Hammerman stating that the amicus brief dated March 3, 1995, inadvertently omitted to include the Euthanasia Research & Guidance Organization (ERGO) as one the interested amici. (cv71)

4/12/95 New party added: Euthanasia Research & Guidance Organization (ERGO), (See letter dated April 10, 1995). (cv71)

4/13/95 New party added: Members of the New York State Legislature. (cv71)

4/13/95 Movant Members NYS Legislature motion to participate as amicus curiae, and to file brief as amicus curiae. FILED (w/pfs). [640243-2] (cv71)

4/17/95 Appellants Timothy E. Quill, Samuel C. Klagsbrun, Howard A. Grossman reply brief filed with proof of service. (cv71)

4/18/95 Order FILED GRANTING motion to participate as amicus [640243-1] by Movant Members NYS Legislature, endorsed on motion form dated 4/13/95. GRANTING motion to file brief as amicus curiae [640243-2] by Amicus Curiae Members NYS Legislature, endorsed on motion form dated 4/13/95. [By: GC] (cv71)

4/18/95 Amicus Curiae Members NYS Legislature brief filed with proof of service. (cv71)

5/15/95 Letter received Carla A. Kerr notifying the Court that she is not available for argument May 30 through June 16, 1995. (cv71)

7/10/95 Proposed for argument the week of 8/28/95. (ca93)

7/18/95 Letter received from appellant counsel with an attached affidavit. To Cal. (cv70)

7/21/95 Set for argument on 9/1/95. [95-7028] (ca92)

8/2/95 Letter received from appellant counsel requesting division of time for argument. To Cal. (cv70)

8/7/95 Order FILED GRANTING motion for permission for both counsel to jointly present oral argument on the appeal [614870-1] by Appellant Timothy E.

Quill, Samuel C. Klagsbrun, Howard A. Grossman, endorsed on motion form dated 2/2/95. (ca91)

9/1/95 Case heard before MINER, CALABRESI CJJ., POLLACK D.J. (Tape: #8) (ca95)

4/2/96 Judgment of the district court is AFFIRMED in part & REVERSED in part by published signed opinion filed. (RJM) [95-7028] (cv70)

4/2/96 Judge Calabresi concurring in a separate opinion filed. (cv70)

4/2/96 Judgment filed. (cv70)

4/8/96 Note: The OPINION PRICE is $10.00 (rek)

4/12/96 Appellee Dennis C. Vacco motion for stay Mandate pending application for a Writ of Certiorari, FILED (w/pfs). [784288-1] To A.A. (cv70)

4/12/96 Appellee Dennis C. Vacco papers supporting motion [784288-1] by Appellee Dennis C. Vacco received. Problem: Oversized memo. Contacted counsel & informed him the Court requires a motion to file said memo. (cv70)

4/12/96 Appellee George E. Pataki, Appellee Dennis C. Vacco motion to file oversized memorandum of law FILED (sent to AA) (w/pfs). [786667-1] (cv79)

4/12/96 Letter received from Claudia Hammerman dated 4-11-96 stating that an amicus party had been omitted from the opinion. (cc panel) (cv71)

4/17/96 Order FILED GRANTING motion for stay of mandate pending application for writ of certiorari [784288-1] by Appellee Dennis C. Vacco, endorsed on motion form dated 4/12/96. (RJM, GC, MP) (cv72)

4/17/96	Order FILED MOOTING motion to file oversize memo [786667-1] by Appellee George E. Pataki, Dennis C. Vacco, on motion dated 4/12/96. Moot in light of Court's Order entered this date. (A.H.) (cv70)
4/23/96	Letter sent to atty Carla Kerr from Beth J. Meador returning the stipulation extending time for costs. (cv71)
5/17/96	Letter received from the SC informing this court that a petition for certiorari was filed in this matter. The normal docketing notice will be sent to you in normal course. (cv70)
5/20/96	Notice of filing petition for writ of certiorari for Appellee Robert M. Morgenthau, Appellee George E. Pataki, Appellee Dennis C. Vacco dated 5/16/96 filed. (Supreme Ct#: 95-1858). (cv71)
7/26/96	Letter received from Susan Levy, requesting copy of decision. (cc: K. Brofsky) (cv71)

IN THE SUPREME COURT OF THE UNITED STATES

No. 95-1858

ORDER GRANTING WRIT OF CERTIORARI,
dated October 1, 1996

Tuesday, October 1, 1996

VACCO, NY ATTY. GEN, ET AL. v. QUILL, TIMOTHY, ET AL.

CERTIORARI GRANTED

The motion of Agudath Israel of America for leave to file a brief as *amicus curiae* is granted. The motion of Carl Anderson, Commissioner, et al. for leave to file a brief as *amici curiae* is granted. The motion of United States Catholic Conference, et al. for leave to file a brief as *amici curiae* is granted. The motion of Catholic Medical Association for leave to file a brief as *amicus curiae* is granted. The petition for a writ of certiorari is granted. The brief of petitioners is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, November 12, 1996. The brief of respondents is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Tuesday, December 10,

1996. A reply brief, if any, is to be filed with the Clerk and served upon opposing counsel on or before 3 p.m., Friday, December 27, 1996. Rule 29.2 does not apply. The case is set for oral argument in tandem with No. 96-110, *Washington v. Glucksberg*.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321
Received July 20, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

Plaintiffs, for their complaint, allege:

PARTIES

1. Jane Doe is a mentally competent, terminally ill adult who resides in Oceanside, New York.

2. George A. Kingsley is a mentally competent, terminally ill adult who resides in New York City.

3. William A. Barth is a mentally competent, terminally ill adult who resides in New York City.

4. Howard A. Grossman, M.D., is a physician licensed in the State of New York who practices internal medicine, primarily treating patients with AIDS, in New York City. Dr. Grossman sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

5. Samuel C. Klagsbrun, M.D., is a physician licensed in the State of New York who practices psychiatry in New York City and Katonah, New York. Dr. Klagsbrun sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

6. Timothy E. Quill, M.D., is a physician licensed in the State of New York who practices internal medicine in Rochester, New York. Dr. Quill sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

7. G. Oliver Koppell, the Attorney General of the State of New York, is the chief law enforcement officer of the State of New York and acts under color of the law in enforcing the New York Penal Law. He is sued in his official capacity and as a representative of all law enforcement officers in the State.

JURISDICTION AND VENUE

8. Plaintiffs bring this action pursuant to 42 U.S.C. § 1983 to redress the deprivation of rights guaranteed by the Fourteenth Amendment to the Constitution of the United States. Plaintiffs seek a declaratory judgment pursuant to the Federal Declaratory Judgments Act, 28 U.S.C. §§ 2201 and 2202, and appropriate injunctive relief. The jurisdiction of this Court is invoked pursuant to 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331 and 1343(a)(3).

9. Venue is properly laid in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

NATURE OF THE ACTION

10. This action seeks a declaratory judgment that the portions of the New York Penal Law sections criminalizing assisted suicide are unconstitutional as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death. This action also seeks appropriate injunctive relief. The sections of the Penal Law provide, in relevant part, that it is a class C felony to intentionally aid another person to commit suicide (N.Y. Penal Law § 125.15(3)), and a class E felony to promote a suicide attempt by intentionally aiding another person to attempt suicide (N.Y. Penal Law § 120.30). By criminalizing physician assistance in these circumstances, the New York Penal Law prevents mentally competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid continued suffering and a lingering, painful death. These portions of sections 125.15(3) and 120.30 deny individuals the liberty and privacy to decide what to do with their own bodies and forces them to endure pain, anguish, and loss of dignity.

FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

11. Jane Doe is a 76-year-old retired physical education instructor who is dying of thyroid cancer. Jane Doe has been advised and understands that her illness is a terminal one, that she is in the terminal phase of her disease, and that there is no chance of recovery. Jane Doe is fully aware of the ravages the disease wreaks and the prospect she faces of progressive loss of bodily function and integrity and increasing pain and suffering. Jane Doe seeks necessary medical assistance in the form of medications prescribed by her physician to be self-administered for the purpose of hastening her death. Without such assistance Jane Doe cannot hasten her death in a certain and humane manner.

12. George A. Kingsley is a 48-year-old publishing industry executive who is suffering from AIDS. Mr. Kingsley has been advised and understands that his illness is a terminal one, that he is in the terminal phase of his disease, and that there is no chance of recovery. Mr. Kingsley is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Kingsley seeks necessary medical assistance in the form of medications prescribed by his physician to be self-administered for the purpose of hastening his death. Without such assistance Mr. Kingsley cannot hasten his death in a certain and humane manner.

13. William A. Barth is a 28-year-old former fashion editor who is suffering from AIDS. Mr. Barth has been advised and understands that his illness is a terminal one, that he is in the terminal phase of the disease, and that there is no chance for recovery. Mr. Barth is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Barth seeks necessary medical assistance in the form of medications prescribed by his physician and a plaintiff herein, Dr. Howard A. Grossman, to be self-administered for the purpose of hastening his death. Without such assistance Mr. Barth cannot hasten his death in a certain and humane manner.

14. There are mentally competent, terminally ill adults in New York, some of whom would decide to hasten their deaths with physician assistance if such a choice were available to them.

15. In the regular course of Dr. Howard A. Grossman's medical practice, Dr. Grossman treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Grossman encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Grossman's medical practice to assist these patients, including plaintiff William A. Barth, in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Grossman from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

16. In the regular course of Dr. Samuel C. Klagsbrun's medical practice, Dr. Klagsbrun treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Klagsbrun encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Klagsbrun's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in

a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Klagsbrun from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

17. In the regular course of Dr. Timothy E. Quill's medical practice, Dr. Quill treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Quill occasionally encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Quill's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law deter Mr. Quill from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

CLAIMS FOR RELIEF

COUNT I

(Violations of Liberty Guaranteed
by Fourteenth Amendment)

18. Plaintiffs repeat and reallege paragraphs 1 through 17 of their Complaint.

19. The Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain

and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

20. The Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

21. Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

COUNT II

(Violation of Equal Protection Guaranteed
by Fourteenth Amendment)

22. Plaintiffs repeat and reallege paragraphs 1 through 17 of their Complaint.

23. The Fourteenth Amendment guarantees patient-plaintiffs Jane Doe, George A. Kingsley and William A. Barth, and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, equal protection under the law of the State of New York. The relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

24. Patient-plaintiffs Jane Doe, George A. Kingsley and William A. Barth, and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, patient-plaintiffs and the patients of the physician-plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

(1) A declaration that the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law are invalid under the Constitution of the United States as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death, and thus violate 42 U.S.C. section 1983.

(2) An order permanently enjoining defendant, and all who act in concert with him, from enforcing the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death.

(3) An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. section 1988.

(4) Such other and further relief as the Court deems just and proper.

DATED: New York, New York
July 20, 1994

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HUGHES HUBBARD & REED

By: CARLA A. KERR
Carla A. Kerr (CK-5194)

One Battery Park Plaza
New York, New York
(212) 837-6000

Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D., *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

ANSWER AND AFFIRMATIVE DEFENSES

Defendant G. Oliver Koppell, by and through counsel, answers plaintiff's complaint, as follows:

1. Denies knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 1, 2, 3, 4, 5 and 6 of the complaint.

2. In response to paragraph 7 of the complaint, admits that G. Oliver Koppell is the Attorney General of the State of New York and respectfully refers the Court to Section 63 of the New York State Executive Law for a description of his duties and responsibilities.

3. Paragraph 8 of the complaint states legal conclusions to which no responsive pleading is required. The Court is

respectfully referred to the statutes cited therein for their contents.

4. Denies the allegations contained in paragraph 10 of the complaint and respectfully refers the Court to the statutes cited therein for their contents.

5. Denies knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 11, 12, 13, 14, 15, 16, and 17 of the complaint.

6. In response to paragraph 18 of the complaint, repeats and realleges his answers to paragraphs 1 through 17 of the complaint and incorporates them by reference.

7. Denies the allegations contained in paragraphs 19, 20, and 21 of the complaint.

8. In response to paragraph 22 of the complaint, repeats and realleges his answers to paragraphs 1 through 17 of the complaint and incorporates them by reference.

9. Denies the allegations contained in paragraphs 23 and 24 of the complaint.

FIRST AFFIRMATIVE DEFENSE

10. The complaint fails in whole or in part to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

11. This action is barred in whole or in part by the Eleventh Amendment to the United States Constitution.

12. The Court lacks jurisdiction over the subject matter.

THIRD AFFIRMATIVE DEFENSE

18. This action does not present a case or controversy under Article III of the Constitution of the United States.

FOURTH AFFIRMATIVE DEFENSE

19. The issue presented is a non-justiciable political question.

WHEREFORE, defendant respectfully demands that the Court enter judgment dismissing the complaint with prejudice.

Dated: New York, New York
August 22, 1994

G. OLIVER KOPPELL
Attorney General of the
State of New York

/s/ MICHAEL S. POPKIN
SUSAN L. WATSON (SW 0023)
MICHAEL S. POPKIN (MP 3209)
Assistant Attorneys General
120 Broadway—24th Floor
New York, NY 10271
212-416-8570

CERTIFICATE OF SERVICE

MICHAEL S. POPKIN, being duly sworn, deposes and says that he is an Assistant Attorney General employed in the office of G. OLIVER KOPPELL, Attorney General of the State of New York, and that on the 22d day of August 1994 he served the annexed upon Carla A. Kerr, Esq., attorney for plaintiff, of the firm of Hughes, Hubbard and Reed, at her designated professional address at One Battery Park Plaza, New York, NY 10004, by depositing a true and conformed copy of the same with the U.S. Postal Service, first class mail, postage prepaid, for delivery to her in the usual course of its business.

/s/ MICHAEL S. POPKIN
MICHAEL S. POPKIN (MP 3209)

Sworn to before me this
22d day of August, 1994

/s/ ILLEGIBLE
Assistant Attorney General
of the State of New York

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)
Filed September 16, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
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Seattle, Washington 98101-3099
(206) 583-8888

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Tracy E. Poole (TP 3484)
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New York, New York 10004
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Attorneys for Plaintiffs

Order to Show Cause

Upon the application of plaintiffs and the accompanying declarations of plaintiffs TIMOTHY E. QUILL, M.D., sworn to on August 26, 1994, SAMUEL C. KLAGSBRUN, M.D., sworn to on August 31, 1994, HOWARD A. GROSSMAN, M.D., sworn to on September 7, 1994, JANE DOE, sworn to on July 28, 1994, GEORGE A. KINGSLEY sworn to on September 13, 1994, WILLIAM A. BARTH, sworn to on September 1, 1994, and the affidavit of CARLA A. KERR, ESQ., sworn to on September 15, 1994, also upon the summons and complaint, and memorandum of law submitted herewith, and upon all prior pleadings and proceedings herein, it is hereby

ORDERED that defendant G. OLIVER KOPPEL show cause before this Court on the 27th day of September, 1994, at 10:00 o'clock a.m., or soon thereafter as counsel may be heard, at the United States Courthouse, Foley Square, New York, New York 10007, in Room 1506, why a preliminary injunction should not be issued pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining defendant, his officers, agents, servants, employees, attorneys, successors in office and all others acting under his authority, control, direction, permission or license, and all persons acting in concert and participation with him from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths;

IT IS FURTHER ORDERED, that no undertaking be filed by the plaintiffs since it does not appear that any damages may be suffered or sustained by any party who is found to be wrongfully enjoined;

IT IS FURTHER ORDERED, that service of this order to show cause together with a copy of the papers submitted in support hereof upon defendant on or before September 16, 1994 at

1:00 o'clock, p.m., shall be deemed sufficient service as to defendant;

IT IS FURTHER ORDERED, that defendant shall serve, by hand, any affidavits, exhibits and/or memorandum of law in opposition upon plaintiffs attorneys on or before September 23, 1994 at 5 o'clock p.m.;

IT IS FURTHER ORDERED, that plaintiffs shall serve any reply affidavits, exhibits and/or memoranda upon defendant on or before September 26, 1994.

Dated: New York, New York
September 15, 1994

/s/ THOMAS P. GRIESA
Chief Judge Thomas P. Griesa
United States District Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)
Received September 15, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

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Attorneys for Plaintiffs

AFFIDAVIT OF CARLA A. KERR, ESQ. IN SUPPORT OF PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

CARLA A. KERR, ESQ. declares:

1. I am associated with the law firm of Hughes Hubbard & Reed which, along with Perkins Coie, is counsel for plaintiffs Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D., Howard A. Grossman, M.D., Jane Doe, George A. Kingsley, and William A. Barth in the above-captioned action. I am duly admitted to practice before this Court and am fully familiar with the facts and circumstances surrounding this action.

2. I submit this declaration in support of plaintiffs' motion for a preliminary injunction enjoining defendant G. Oliver Koppell from enforcing New York Penal Law sections 125.15(3) and 120.30, which prohibit aiding in a suicide and aiding in a suicide attempt, against physicians who prescribe drugs that suffering, terminally ill patients request to hasten their own impending deaths.

3. Plaintiff Jane Doe was a terminally ill, competent adult who suffered from the effects of the advanced stages of cancer. She died subsequent to the commencement of this action. However, her supporting declaration accompanies this motion. Ms. Doe's signature, in her true name, has been redacted from the Court's copy of the declaration to preserve her privacy. The original signed declaration is maintained in the law offices of Hughes Hubbard & Reed. Due to the advanced stages of AIDS suffered by plaintiffs George A. Kingsley and William A. Barth at this time, we respectfully request that the Court grant the relief sought immediately.

4. Plaintiffs Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D. and Howard A. Grossman, M.D., all licensed physicians who specialize in the treatment of the terminally ill, submit

their declarations and bring this motion on behalf of themselves and their terminally ill patients.

5. The accompanying declarations of the patient plaintiffs evidence the pain and suffering that plaintiffs are forced to endure prior to their deaths because of enforcement of the subject Penal Law provisions. Additionally, the declarations of the physician plaintiffs reflect both their inability to fulfill their professional responsibilities as a result of the Penal Law as well as the suffering of their patients whose interests they assert herein.

6. New York Penal Law section 125.15 provides in pertinent part:

> A person is guilty of manslaughter in the second degree when:
>
> . . .
>
> 3) He intentionally . . . aids another person to commit suicide.
>
> Manslaughter in the second degree is a class C felony.

7. New York Penal Law section 120.30 provides in pertinent part:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.
>
> Promoting a suicide attempt is E felony.

The Penal Law does not criminalize suicide or the attempt to commit suicide, and suicide is not defined by statute.

8. As fully set forth in the accompanying memorandum of law in support of plaintiffs' motion, Penal Law sections 125.15(3) and 120.30 are unconstitutional as applied to physician assistance in dying because the sections intrude upon an individual's fundamental rights to liberty and equal protection which are guaranteed by the Fourteenth Amendment. The

Court in *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992), found that the Constitution affords protection to "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education" because they are among the matters "fundamentally affecting a person." Likewise, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 241, 278 (1990), the Court stated that "a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." The Court in *Cruzan* also acknowledged that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment" and in that manner causing his or her own death. *Id.* at 278, 267-68. Thus, the Constitution, supported by the interpretations of the Supreme Court, protects the decision of a mentally competent, terminally ill adult to hasten death with physician assistance. Defendants therefore, must be enjoined from enforcing the subject Penal Law provisions against plaintiffs George Kingsley's and William A. Barth's personal decisions as to whether to hasten their inevitable deaths.

9. The subject sections of the Penal Law also violate the Equal Protection Clause because the sections criminalize the same conduct sanctioned by New York statutory and common law. New York permits individuals, through health care agencies and proxies established while competent, to make all personal health care decisions in the event of incapacity. As fully briefed in plaintiffs' accompanying memorandum of law, relevant case law supports an individual's right to refuse medical treatment, thereby hastening death. This right is considered a "fundamental common-law right" that is "coextensive with the patient's liberty interest protected by the due process clause of our state Constitution." *Rivers v. Katz*, 67 N.Y.2d 485, 493, 504 N.Y.2d 74, 495 N.E.2d 337 (1986). Thus, the Penal Law sections which criminalize physician-assisted hastening of death for the terminally ill prevent one group from receiving the very same protection afforded another group of similarly-situated individuals.

10. The irreparable harm suffered by plaintiffs is clear. The terminally ill plaintiffs have suffered, and in the cases of plaintiffs Kingsley and Barth continue to suffer, both physically and emotionally as outlined in their supporting declarations. Unless this Court issues an injunction, Mr. Kingsley's and Mr. Barth's suffering will increase until they eventually succumb to their disease and the physician plaintiffs will be forced to violate their professional obligations or be subject to criminal prosecution. Likewise absent this issuance of an injunction, the terminally ill patients, on whose behalfs the physician plaintiffs bring this action, will also be prevented from exercising their constitutionally protected right.

11. For the aforementioned reasons, and as discussed in plaintiffs' supporting memorandum of law, plaintiffs have a likelihood of success on the merits.

12. Plaintiffs have no adequate remedy at law.

13. No prior application has been made for the relief requested herein.

/s/ CARLA A. KERR
Carla A. Kerr

Sworn to me before this
15 day of September, 1994

/s/ GEORGE A. TSOUGARAKIS
Notary Public

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

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(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF TIMOTHY E. QUILL, M.D.

Timothy E. Quill, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in General Internal Medicine and am a Primary Care Internist. I am licensed to practice medicine in the State of New York.

3. I received my medical education at the University of Rochester School of Medicine, graduating in 1976.

4. From 1976 through 1979, I served a residency in Primary Care Internal Medicine with the University of Rochester.

5. I then served a two-year Medical Psychiatric Liaison Fellowship at the University of Rochester School of Medicine.

6. In the 1980–1981 academic year, I served as Senior Instructor in Medicine and Psychiatry at the University of Rochester School of Medicine.

7. From 1981 through 1988, I served as Clinical Assistant Professor of Medicine and Psychiatry at the University of Rochester School of Medicine; in 1982 I received the Clinical Faculty Teaching Award of the Associated Hospitals Program; in 1984 I was the recipient of the Frederick W. Anderson Teaching Award of the Genesee Hospital.

8. From 1981 through 1988, I served as the Medical Director of the Genesee Region Home Care Home Hospice Program.

9. From 1988 through 1989, I served as Assistant Professor of Medicine and Psychiatry at the University of Rochester School of Medicine.

10. From 1990 through 1993, I served as an Associate Professor in Medicine and Psychiatry.

11. In 1994 I was promoted to Professor of Medicine and Psychiatry.

12. From 1989 to the present, I have served as Associate Chief of Medicine at the Genesee Hospital in Rochester, New York. I am also the Director of the Program for Biopsychosocial Studies at the University of Rochester and the Director of a Fellowship in Advanced Biopsychosocial Studies.

13. I am Board Certified by the American Board of Internal Medicine; I am a Fellow of the American College of Physicians; I am a member of Alpha Omega Alpha Society; I am a Diplomat of the National Board of Medical Examiners; I am a member of the Society of General Internal Medicine; I am a member of the Steering Committee, and a senior facilitator for the American Academy on Physician and Patient.

14. I have frequently served as a lecturer, visiting professor, seminar leader, workshop organizer and group facilitator on the subjects of medical interviewing, doctor-patient relationship, psychosomatic medicine and end of life decision making at medical schools, universities, colleges and public forums.

15. I have authored numerous articles, book chapters, and a book on the subjects outlined above, with a recent focus on end-of-life decision making. My full curriculum vitae is attached hereto as Exhibit A.

16. As a Primary Care Internist I treat patients with a wide variety of medical conditions. Some of these conditions include terminal illnesses such as metastatic cancer, AIDS, and end-stage pulmonary disease. As the primary care physician for a patient suffering from any terminal illness, I maintain a trusting relationship with such a patient even though that patient may also be seeing a specialist. I am committed to working with my patients to the end of their lives, no matter what course their illness takes.

17. Patients dying of cancer, AIDS, end-stage pulmonary disease and other terminal illnesses can sometimes experience a steady deterioration of functional ability, intractable pain, fatigue, other unrelievable physical symptoms (nausea, vomiting, shortness of breath, foul-smelling wounds) and mental anguish.

18. At a certain point in the progression of these illnesses there are no further curative treatment options that have a reasonable chance of success. The main goal of treatment under these circumstances is to treat complications, relieve symptoms and maintain personal integrity until death inevitably comes.

19. When effective disease controlling or curing treatments are not available, a variety of care options to maximize the patients' well-being and comfort are available, often under the auspices of a hospice program. I was a hospice medical director for eight years, and believe wholeheartedly in the efficacy and appropriateness of hospice methods and philosophy as the standard of care for dying patients.

20. However, at a certain point in the course of these progressive, terminal diseases, some patients are not able to be kept comfortable while maintaining a clear consciousness; the amount of pain medication necessary to resolve their pain causes loss of mental alertness and sometimes consciousness. Thus, some patients face the choice of enduring intractable pain or surrendering an alert mental state. Many patients will choose one or the other of these options; however some patients do not want to end their ways either wracked with pain or in a drug-induced stupor.

21. Furthermore, other terminally ill patients develop unrelievable physical symptoms such as intractable nausea and vomiting, shortness of breath, foul-smelling wounds and other symptoms. Sometimes these symptoms are also unrelievable short of being sedated to unconsciousness, which some patients find unacceptable.

22. For some terminally ill patients, concerns regarding physical symptoms are secondary to their mental anguish over their helplessness, and loss of independence, physical integrity, dignity and autonomy. Some patients feel as if they are disintegrating as a person, and wish for death as the only way to preserve their integrity.

23. I occasionally encounter mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths. These patients either lack any means to hasten their deaths or have access only to methods that have significant risk of failure and increased anguish and pain.

24. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational, and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death when palliative care becomes ineffective or unacceptable if the patient so chooses.

25. Under the statutes prohibiting assisted suicide, my fulfillment of this professional responsibility exposes, and has in the past exposed, me to criminal investigation and/or prosecution. These statutes deter me from treating these patients as I believe I should and deprive my patients of their freedom to choose this type of medical care.

26. I recently had an experience where, in my professional judgment, a terminally ill patient of mine who intentionally chose to hasten her death was making a fully informed, rational decision and my professional responsibility required that I provide medical advice and assistance:

a. In 1990 a patient who had been in my care for 8 years developed acute leukemia. Instead of choosing aggressive medical intervention (chemotherapy, total body irradiation, and bone marrow transplantation) with only a 25 percent chance of cure and multiple, severe adverse side effects, "Diane" chose to spend the time

that she had remaining at home with her family and friends. After ensuring that she was fully informed about what she was giving up, she was offered hospice care to make the most of her remaining life and to ensure that she was kept as comfortable and symptom free as possible. While "Diane" appreciated the benefits of hospice, she feared a lingering death. She wanted to live until her suffering became intolerable, and then she wanted to die as quickly and painlessly as possible. She made it clear that she would act on her own to hasten her death when that point was reached if I refused to assist her in dying and that she would be preoccupied about how to achieve this until she had a fail-safe way out.

b. After extensive discussions with "Diane" and her family, it was my medical judgment that she was making a rational decision to forego treatment and that her desire to hasten her death at the point at which her suffering became intolerable also was rational. I believed "Diane" needed to know that physician-assisted death would be available in order to enjoy her remaining time with her family and friends. I therefore made barbiturates available to "Diane" which she could use to enable sleep, but which she could also take to end her life if all other avenues to relieve her suffering had been exhausted. She agreed to meet with me prior to taking an overdose to ensure that all alternatives had been considered.

c. "Diane" lived for three months after receiving the prescription, in a formal home hospice program. She enjoyed high quality time with her family, and took several life-prolonging treatments such as transfusions and antibiotics. Eventually, "Diane" began to experience such severe pain that she had to make moment-to-moment choices between enduring severe pain or being sedated. She also had fevers indicative of severe infection that were not responding to antibiotics. It was clear that her life expectancy ranged from hours to at most a

week, and that during this time she would experience suffering, anguish and loss of dignity. After meeting with me to ensure that all alternatives had been explored, she took the barbiturates in an overdose and died. She did so alone because she had researched the law in the State of New York, and found that anyone who was with her might be vulnerable to prosecution.

d. In an effort to stimulate discussion about these issues, I subsequently described these events in an article published in the *New England Journal of Medicine*. A copy of this article is attached hereto as Exhibit B. A very public criminal investigation ensued. "Diane's" body, which she had donated to medical science, was subjected to an unwanted autopsy confirming the overdose. A Grand Jury was impaneled to consider whether I should be prosecuted under the New York statute prohibiting assisted suicide. I testified before the Grand Jury, along with "Diane's" spouse and several medical colleagues. The Grand Jury decided against prosecution.

27. I make a commitment to my terminally ill patients that I will not abandon them no matter what happens in the course of their illness. On occasion patients reach a point where their suffering is intolerable and unrelievable and they seek to hasten death. Though relatively few patients actually reach the point where they would act to hasten death, many of my patients fear reaching that point and seek reassurance that I will assist them in dying if they do.

28. I believe that the commitment to help dying patients achieve an end that is acceptable to them is a fundamental professional responsibility for physicians who are committed to the humane care of the dying. I also believe that we have a medical responsibility to respond to those terminally ill patients who reach a point where they are experiencing intolerable suffering that can only be relieved by their deaths. For most patients, hospice care is effective and physician-assisted

death is a reassuring possibility that never has to be acted upon. But for a relatively few dying patients, who suffer intolerably in spite of extensive efforts at palliation, assistance in dying is a welcome alternative to further suffering.

29. Although I was not successfully prosecuted under the New York statutes prohibiting assisted suicide, the fear of having to go through such an ordeal in the future deters me from responding to requests for assistance in dying that I would otherwise deem part of my professional responsibilities.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: August 26, 1994
New York, New York

/s/ TIMOTHY E. QUILL, M.D.
TIMOTHY E. QUILL, M.D.

TIMOTHY E. QUILL, M.D.

CURRICULUM VITAE

CURRENT APPOINTMENTS:

Associate Chief of Medicine
The Genesee Hospital, Rochester NY

Professor of Medicine and Psychiatry
University of Rochester School of Medicine and Dentistry

Director, Program for Biopsychosocial Studies

Primary Care Internist

EDUCATIONAL BACKGROUND:

Amherst College, Amherst, Mass.	B.A.	1971
University of Rochester School of Medicine and Dentistry	M.D.	1976
Residency in the Associated Hospitals Program, University of Rochester	R1, R2, R3 Internal Medicine	1976–1979
Fellowship, University of Rochester School of Medicine	Medical Psychiatric Liaison Fellowship	1979-1981

PREVIOUS FACULTY APPOINTMENTS:

Senior Instructor in Medicine and Psychiatry	Univ. of Rochester School of Medicine	1980–81
Clinical Assistant Professor of Medicine and Psychiatry	Univ. of Rochester School of Medicine	1981–88

Assistant Professor of Medicine and Psychiatry	Univ. of Rochester	1988–89
Associate Professor of Medicine and Psychiatry	Univ. of Rochester	1989–94
Professor of Medicine and Psychiatry	Univ. of Rochester	7/94–present

PROFESSIONAL AFFILIATIONS:

American Board of Internal Medicine, Board Certified in 1979
American College of Physicians (Fellow 1986)
Alpha Omega Alpha
National Board of Medical Examiners (Diplomat)
Society of General Internal Medicine
American Academy on Physician and Patient

ACADEMIC AWARDS:

Benjamin Rush Prize for distinguished scholarship and outstanding skills in psychiatry demonstrated while undergraduate medical student, 1976

Graduation speaker to the University of Rochester Medical School Class of 1976

Clinical Faculty Teaching Award, Associated Hospitals Program, 1982

The Frederick W. Anderson Teaching Award, The Genesee Hospital, 1984

LECTURESHIPS AND VISITING PROFESSORSHIPS:

Faculty for SREPCIM Faculty Development Course on the Medical Interview and related skills, Springfield, Mass. —1985

Faculty for National Faculty Development Course on Medical Interviewing, doctor-patient relationships, and communication dynamics. Portland, Oregon, 1987

Faculty at New England SREPCIM Workshop on Medical Interviewing, University of Massachusetts Medical Center—1987

Faculty for regional Faculty Development course on the Medical Interview and Related Skills, Portland, Oregon, 1986

Visiting Professor at the University of North Carolina at Chapel Hill, General Medical Unit, 1987

Visiting Professor at Worcester Memorial Hospital, Worcester, Mass., 1988 Faculty for national Faculty Development Course on Medical Interview and related skills, Brigham and Women's Hospital, Boston, Mass. 1988.

Faculty, Faculty Development Course on Teaching Medical Interviewing and Related Skills, Ben Gurion University Medical School, Israel, 1989.

Workshop Leader, National ACP Meeting, Panic Attacks and Other Anxiety disorders: Recognition and Treatment in Primary Care Practice, San Francisco, CA 4/89

Workshop Leader, National SGIM Meeting, Panic Attacks and Other Anxiety Disorders: Recognition and Treatment in Primary Care, Arlington, VA 4/89.

Faculty, Faculty Development course on the Medical Interview, Univ. of Massachusetts, Worcester, MA 9/89.

Visiting Lecturer on "Anxiety" at Mary McFarland Hospital, Albany Medical College, 12/89

Visiting Professor, Department of Medicine, Oregon Health Sciences University School of Medicine, Portland, Oregon, 2/90.

Workshop leader, "Anxiety Disorders in Primary Care" Symposium, University of Oklahoma College of Medicine, Tulsa, OK, 1/90.

Visiting Professor in the Department of Medicine, Oregon Health Sciences University, Portland, Oregon 2/90.

Faculty, Facilitator Training Course, Tulsa University, Oklahoma City, OK 9/90.

Faculty, Teaching Interviewing Skills Faculty Development Course, University of Oklahoma, Oklahoma City, OK 9/90.

Faculty, SGIM Faculty Development course on Teaching Medical Interviewing, University of Rochester, NY 6/91.

Faculty, AIDS for Primary Care Givers Faculty course, NYU Medical Center, 3/91.

Visiting Professor, Department of Medicine, Yale University, 11/91.

Visiting Lecturer on "Death, Dignity and Individualized Decision Making at Amherst College, Amherst, Mass. 12/91.

Visiting Lecturer on "Negotiating Death: How far should we go?" at Ethics Symposium at the University of Pennsylvania and the VA Medical Center, Philadelphia, PA. 5/92.

Visiting Lecturer on "Comfort Care of the Dying: Potentials and Limitations", Community Hospital of Lancaster, 1/93.

Visiting Professor at Emory University, Department of Psychiatry, Atlanta, Georgia, 2/93.

Visiting Lecturer on "Physician-Assisted Dying: Clinical and Legal Implications" Allegheny Hospital, University of Pittsburgh, 3/93.

Visiting Lecturer on "Physician-Assisted Dying", University of Virginia, Charlottesville, VA, 4/93.

Visiting Professor, New York University Medical Center, NYC, 5/93.

Visiting Lecturer at Medical Ethics Conference, LDS Hospital, University of Utah School of Medicine, Salt Lake City, Utah, 6/93.

Visiting Lecturer on Death and Dignity, Alfred University, Alfred, NY, 9/93.

Visiting Lecturer at Albany Law School, Albany, New York, 11/93

Visiting Lecturer at Cleveland Academy of Medicine, Cleveland, OH, 11/93

Visiting Lecturer at Colorado Springs Osteopathic Foundation, Colorado Springs, Colorado, 11/93.

Visiting Lecturer, North Memorial Med. Center, Robbinsdale, Minnesota, 12/93.

Visiting Lecturer, Rush University, Chicago, Illinois, 12/93.

Visiting Lecturer, Highland Park Hospital, Highland Park, Illinois, 12/93.
Visiting Lecturer, City of Hope Medical Center, Duarte, California, 2/94.
Visiting Lecturer, St. Barnabas Hospital/Cornell Med. Center, Bronx, NY, 2/94.
Visiting Lecturer, Jefferson County Med. Society, Louisville, Kentucky, 3/94.
Visiting Lecturer, St. John Fisher College, Rochester, NY, 4/94.
Visiting Lecturer, St. Luke's/Cook County Hospital, Chicago, Illinois, 5/94.
Visiting Lecturer, Garrett Theological Seminary, Evanston, Illinois, 5/94.

ADMINISTRATIVE ACTIVITIES:

Associate Chief of Medicine, The Genesee Hospital. 3/88–present
Head, Internal Medicine Division, The Genesee Hospital. 1980–present
Director, Fellowship in Advanced Biopsychosocial Studies (1984–present)
Chairman, CPR Committee, The Genesee Hospital
Member, Physician Assistant Committee, The Genesee Hospital

CONSULTANTSHIPS, BOARD MEMBERSHIPS, ADVISORY POSITIONS, SPECIAL ASSIGNMENTS:

Faculty at national and numerous regional and local Faculty Development Courses on the medical interview and related skills sponsored by the Society of General Internal Medicine.
Executive Committee member, American Academy on Physician and Patient, formerly the Task Force on Doctor and Patient of SGIM, 1985 to present.
Medical Director of Hospice Program, Genesee Region Home Care Association. 1984–88

Manuscript Reviewer for *Annals of Internal Medicine*, *Archives of Internal Medicine*, *Journal of the American Medical Association*, and *Journal of General Internal Medicine*.
Development and implementation of a model resuscitation policy at The Genesee Hospital.
Advisory Panel member, American Psychiatric Association's Panic Disorder Committee, 1989.
New York State Primary Care Advisory Panel, 1989
New York State Advisory Panel on Do-Not-Resuscitate, 1990.
Member, Professional Advisory Board, Death with Dignity Education Center, 1994.
Advisor, Task Force on Suicide and Assisted Dying of the American Association of Suicidology, 1994.
Member, Advisory Council, Choice in Dying, Inc. 1993–present

PRESENTATIONS AT MAJOR NATIONAL MEETINGS:

Presentation at SREPCIM Meeting on "Health-Care Seeking by Men During Their Spouse's Pregnancy", Washington DC. 1982
Presentation at SREPCIM Meeting on Medical Interviewing, Springfield, Mass. 1985.
Presentation at SREPCIM Meeting on Somatization, Washington, DC. 1985
Presentation at ABSAME Meeting on Somatization, Chevy Chase, MD. 1985
Presentation at the American Psychosomatic Society Annual Meeting on SREPCIM's approach to teaching about psychosocial aspects of care. Phila., PA. 1987
Presentation at ACP Workshop Improving Clinical Teaching, Cooperstown NY 1987
Presentation at ACP Workshop on Patient Activation, NY, NY. 1988
Presentation on "Diagnosis of Anxiety Disorders", Anxiety Awareness Board Boston, MA 9/88.

Presentation at Anxiety Disorders in Primary Care Symposium on "Assessing the Anxious Patient", Phoenix, AZ 11/88

Presentation on Somatization Disorder to the Canadian Royal College of Physicians, Edmonton, Canada 2/89.

Presentation at National ACP and SGIM Meetings, Panic Attacks & Anxiety Disorders: Recognition & Treatment in Primary Care, Washington, DC 1989.

Presentation at national ACP and SGIM Meetings, Panic Attacks and Other Anxiety Disorders, Chicago and Washington, D.C., respectively, April/May 1990.

Presentation at National SGIM Meeting on Delivering the Bad News. Washington, D.C., 5/90.

Presentation at American Academy of Emergency Physicians' Annual Meeting on Panic Disorder, San Francisco, CA, 9/90.

Presentation at National ACP and SGIM Meetings, Anxiety Disorders and Panic Attacks, New Orleans and Seattle, respectively, April/May 1991.

Presentation on "Panic Disorders" at American College of Emergency Physicians Annual Meeting, Boston, MA 10/91.

Presentation on "Physician-Assisted Dying: Progress or Peril" at the American Society for Law and Medicine Meeting, Chicago, IL. 4/92.

Presentation and workshop coordinator at National ACP Meeting on Biopsychosocial Problems in Primary Care, Washington, DC 5/92.

Presentation at National SGIM Meeting on Aid in Dying and Delivering Bad News. Washington, DC 5/92.

Presentation on "Debate on Active Euthanasia" at National APA Meeting, Washington, DC 5/92.

Presentation on "Assisted Suicide—Moral and Medical Implications" at the Washington National Cathedral, Washington, DC 5/92.

Keynote speaker at Symposium on Patient-Professional Communication and Ethical Issues in the 1900's, Oregon Health Sciences University, Center for Ethics in Health Care, 9/92.

Presentation at Conference on "Care of the Dying Patient", Midwest Bioethics Center, Kansas City, Missouri, 10/92.

Presentation at 1992 Annual Meeting of the American Society of Law and Medicine on "Working with Dying Patients", Boston, MA 2/92.

Presentation at Managing Mortality Conference, Center for Biomedical Ethics, Minneapolis, Minnesota, 12/92.

Presentation at AMA Leadership Conference on "Physician-Assisted Suicide", Atlanta, Georgia, 2/93.

Visiting Lecturer at Massachusetts Medical Society Symposium on Physician Assisted Suicide, Boston, MA, 10/93.

Visiting Lecturer at ACP Regional Meeting, Cape Cod, MA, 10/93.

Visiting Lecturer, American Assoc. of Suicidology, New York, NY, 4/94.

FILMS:

Protagonist for the American College of Physicians' Health Scope Series film entitled "Stress and Illness" 1985-86.

Advisory Board for Television program filming of "Living Well" produced by Vision Associates, NY, NY. (On PBS 1990)

Advisor and Participant in an American Academy of Family Physician and Upjohn Company CME videotape and monograph on "The Diagnosis and Treatment of Anxiety Disorders." (1991)

American Medical Association Documentary on "Medical Ethics", 1992

PUBLICATIONS:

Quill TE, Goldstein M and Schmale A. "Early experience with death in medical school—an approach to sensitization." Paper included in symposium on Thanatology and Medical Education in New York City, 1977.

Schmale A and Quill TE. To Live is to Die—Dealing with Death and Dying. Oncology Module #3, part of the undergraduate psychiatry curriculum (Unpublished)

Quill TE. Care for Chronic Pain (Letter to the Editor). *Annals of Internal Medicine* 94:1(134), January 1981.

Quill TE. Primary Care: How special is medicine's nonspecialty? *The Pharos*, Vol. 45:1, Winter 1982, page 25-30.

Quill TE. Partnerships in patient care: A contractual approach. *Annals of Internal Medicine* 1983;98:228-234.

Lipkin M, Quill TE and Napodano RJ. The Medical Interview: A core curriculum for residencies in internal medicine, *Annals of Internal Medicine* 1984;100:277-284.

Quill TE, Lipkin M, and Lamb GS. Health-care seeking by men in their spouse's pregnancy. *Psychosomatic Medicine* 1984;46:277-283.

Book Review—Quill TE. The Consultation, *Annals of Internal Medicine*, October 1984, Vol. 101:4, p. 577.

Quill TE. (Editorial) Patient-centered medicine: Increasing patient responsibility in medical care. *Hospital Practice*, 1985;20:6-17.

Quill TE. Somatization disorder: One of medicine's blind spots. *JAMA* 1985;254:3075-3079.

Fiore W, Penn TE, Quill T, et.al. Giant cell arteritis in a 20 year old black man: A cause of intermittent calf claudication. *J of Vascular Surgery* 1986;4:192-195.

Quill TE. Where's the Resistance? (Where's the Beef?) *Medical Encounter* (Newsletter of SREPCIM Task Force on the Medical Interview), April 1986, 3:2-4.

Quill TE, Stankaitis JA, Krause CR. The effect of a community hospital resuscitation policy on geriatric patients. *NYS Journal of Medicine*, 1986;622-625.

Quill TE. Medical Resident Education: A Cross-sectional Study of the Influence of the Ambulatory Preceptor as a Role Model, *Archives of Internal Medicine*, 1987;147:971-973.

Quill TE. The Patient with Chronic Pain: A Biopsychosocial Approach. *HMO Practice*, 1987;1:98-104.

Quill TE, Lipkin M, Greenland P. The Medicalization of Normal Variants: The Case of Mitral Valve Prolapse, 1988, *Journal of Gen Int Med* 1988; 3:267-276.

Quill TE. (contributing author) *Diagnosis and Treatment of Anxiety Disorders: A Physician's Handbook*. McGlynn TJ and Metcalf HL (Eds.) American Psychosomatic Press, Inc., 1988.

Quill TE. Recognizing and Calibrating to Barriers in Doctor-Patient Communication. *Ann Intern Med* 1989;111:51-57.

Quill TE. Utilization of Nasogastric Tubes in a Group of Chronically Ill, Elderly Patients in a Community Hospital *Arch of Int Med* 1989; 149:1937-1941.

Quill TE, Williamson PR. Healthy approaches to physician stress. *Arch of Int Med* 1990;150:1857-61.

Rost K, Roter D, Bertakis K, Quill T. Physician-patient familiarity and patient recall of medication changes. *Family Medicine* 1990;22:453-57.

Rost K, Roter D, Quill T, Bertakis K. Capacity to remember drug changes: Deficits associated with diabetes. *Diabetes Res and Clin Prac* 1990:10:183-87.

Quill TE, Townsend P. Bad News: Delivery, Dialogue and Dilemmas. *Archives of Internal Medicine* 1990;151:463-468.

Quill TE. Death and Dignity: A Case of Individualized Decision Making. *NEJM* 1991;324:691-94.

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Quill TE, Bennett NM. The effect of a hospital policy and state legislation on resuscitation orders for geriatric patients. *Archives of Internal Medicine* 1992;152:569-92.

Quill TE, Cassel C, Meier D. Care of the Hopelessly Ill: Potential Criteria for Physician-Assisted Suicide. *NEJM* 1992;327:1380-84.

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Quill TE. Barriers to Effective Communication. Chapter in *The Medical Interview*, Lipkin, Putnam, Lazare (Ed). New York: Springer-Verlag, 1994 (In Press)

BOOKS:

Quill TE. *Death and Dignity: Making Choices and Taking Charge*. New York: W.W. Norton & Co., 1993.

SOUNDING BOARD

DEATH AND DIGNITY
A Case of Individualized Decision Making

Reprinted from the *New England Journal of Medicine*
March 7, 1991

DIANE was feeling tired and had a rash. A common scenario, though there was something subliminally worrisome that prompted me to check her blood count. Her hematocrit was 22, and the white-cell count was 4.3 with some metamyelocytes and unusual white cells. I wanted it to be viral, trying to deny what was staring me in the face. Perhaps in a repeated count it would disappear. I called Diane and told her it might be more serious than I had initially thought—that the test needed to be repeated and that if she felt worse, we might have to move quickly. When she pressed for the possibilities, I reluctantly opened the door to leukemia. Hearing the word seemed to make it exist. "Oh, shit!" she said. "Don't tell me that." Oh, shit! I thought, I wish I didn't have to.

Diane was no ordinary person (although no one I have ever come to know has been really ordinary). She was raised in an alcoholic family and had felt alone for much of her life. She had vaginal cancer as a young woman. Through much of her adult life, she had struggled with depression and her own alcoholism. I had come to know, respect, and admire her over the previous eight years as she confronted these problems and gradually overcame them. She was an incredibly clear, at times brutally honest, thinker and communicator. As she took control of her life, she developed a strong sense or independence and confidence. In the previous $3^{1}/_{2}$ years, her hard work had paid off. She was completely abstinent from alcohol, she had established much deeper connections with her husband, college-age son, and several friends, and her business and her artistic work were blossoming. She felt she was really living fully for the first time.

Not surprisingly the repealed blood count was abnormal, and detailed examination of the peripheral blood smear showed myelocytes. I advised her to come into the hospital, explaining that we needed to do a bone marrow biopsy and make some decisions relatively rapidly. She came to the hospital knowing what we would find. She was terrified, angry, and sad. Although we knew the odds, we both clung to the thread of possibility that it might be something else.

The bone marrow confirmed the worst: acute myelomonocytic leukemia. In the face of this tragedy, we looked for signs of hope. This is an area of medicine in which technological intervention has been successful, with cures 25 percent of the time—long-term cures. As I probed the costs of these cures, I heard about induction chemotherapy (three weeks in the hospital prolonged neutropenia, probable infectious complications, and hair loss; 75 percent or patients respond, 25 percent do not). For the survivors, this is followed by consolidation chemotherapy (with similar side effects; another 25 percent die for a net survival of 50 percent). Those still alive, to have a reasonable chance or long-term survival, then need bone marrow transplantation (hospitalization for two months and whole-body irradiation, with complete killing of the bone marrow, infectious complications, and the possibility for graft-versus-host disease—with a survival of approximately 50 percent, or 25 percent or the original group). Though hematologists may argue over the exact percentages, they don't argue about the outcome of no treatment—certain death in days, weeks, or at most a few months.

Believing that delay was dangerous, our oncologist broke the news to Diane and began making plans to insert a Hickman catheter and begin induction chemotherapy that afternoon. When I saw her shortly thereafter, she was enraged at his presumption that she would want treatment, and devastated by the finality of the diagnosis. All she wanted to do was go home and be with her family. She had no further questions about treatment and in fact had decided that she wanted none. Together we lamented her tragedy and the unfairness of

life. Before she left, I felt the need to be sure that she and her husband understood that there was some risk in delay, that the problem was not going to go away, and that we needed to keep considering the options over the next several days. We agreed to meet in two days.

She returned in two days with her husband and son. They had talked extensively about the problem and the options. She remained very clear about her wish not to undergo chemotherapy and to live whatever time she had left outside the hospital. As we explored her thinking further, it became clear that she was convinced she would die during the period of treatment and would suffer unspeakably in the process (from hospitalization, from lack or control over her body, from the side effects of chemotherapy, and from pain and anguish). Although I could offer support and my best effort to minimize her suffering if she chose treatment, there was no way I could say any or this would not occur. In fact, the last four patients with acute leukemia at our hospital had died very painful deaths in the hospital during various stages of treatment (a fact I did not share with her). Her family wished she would choose treatment but sadly accepted her decision. She articulated very clearly that it was she who would be experiencing all the side effects or treatment and that odds or 25 percent were not good enough for her to undergo so toxic a course of therapy, given her expectations of chemotherapy and hospitalization and the absence of a closely matched bone marrow donor. I had her repeat her understanding of the treatment, the odds, and what to expect if there were no treatment. I clarified a few misunderstandings but she had a remarkable grasp of the options and implications.

I have been a longtime advocate of active informed patient choice of treatment or nontreatment, and of a patient's right to die with as much control and dignity as possible. Yet there was something about her giving up a 25 percent chance or long-term survival in favor of almost certain death that disturbed me. I had seen Diane fight and use her considerable inner resources to overcome alcoholism and depression, and

I half expected her to change her mind over the next week. Since the window of time in which effective treatment can be initiated is rather narrow, we met seven times that week. We obtained a second hematology consultation and talked at length about the meaning and implications of treatment and nontreatment. She talked to a psychologist she had seen in the past. I gradually understood the decision from her perspective and became convinced that it was the right decision for her. We arranged for home hospice care (although at that time Diane felt reasonably well, was active, and looked healthy), left the door open for her to change her mind, and tried to anticipate how to keep her comfortable in the time she had left.

Just as I was adjusting to her decision, she opened up another area that would stretch me profoundly. It was extraordinarily important to Diane to maintain in control of herself and her own dignity during the time remaining to her. When this was no longer possible, she clearly wanted to die. As a former director of a hospice program, I know how to use pain medicines to keep patients comfortable and lessen suffering. I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible. Knowing of her desire for independence and her decision to stay in control, I thought this request made perfect sense. I acknowledged and explored this wish but also thought that it was out of the realm of currently accepted medical practice and that it was more than I could offer or promise. In our discussion, it became clear that preoccupation with her fear of a lingering death would interfere with Diane's getting the most out of the time she had left until she found a safe way to ensure her death. I feared the effects of a violent death on her family, the consequences of an ineffective suicide that would leave her lingering in precisely the state she dreaded so much, and the possibility that a family member would be forced to

assist her, with all the legal and personal repercussions that would follow. She discussed this at length with her family. They believed that they should respect her choice. With this in mind, I told Diane that information was available from the Hemlock Society that might be helpful to her.

A week later she phoned me with a request for barbiturates for sleep. Since I knew that this was an essential ingredient in a Hemlock Society suicide, I asked her to come to the office to talk things over. She was more than willing to protect me by participating in a superficial conversation about her insomnia, but it was important to me to know how she planned to use the drugs and to be sure that she was not in despair or overwhelmed in a way that might color her judgment. In our discussion, it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring—spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

The next several months were very intense and important for Diane. Her son stayed home from college, and they were able to be with one another and say much that had not been said earlier. Her husband did his work at home so that he and Diane could spend more time together. She spent time with her closest friends. I had her come into the hospital for a conference with our residents, at which she illustrated in a most

profound and personal way the importance of informed decision making, the right to refuse treatment, and the extraordinary personal effects of illness and interaction with the medical system. There were emotional and physical hardships as well. She had periods or intense sadness and anger. Several times she became very weak, but she received transfusions as an outpatient and responded with marked improvement of symptoms. She had two serious infections that responded surprisingly well to empirical courses of oral antibiotics. After three tumultuous months, there were two weeks of relative calm and well-being, and fantasies of a miracle began to surface.

Unfortunately, we had no miracle. Bone pain, weakness, fatigue, and fevers began to dominate her life. Although the hospice workers, family members, and I tried our best to minimize the suffering and promote comfort, it was clear that the end was approaching. Diane's immediate future held what she feared the most—increasing discomfort, dependence, and hard choices between pain and sedation. She called up her closest friends and asked them to come over to say goodbye, telling them that she would be leaving soon. As we had agreed, she let me know as well. When we met it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva with dragons swimming in the sunset.

Two days later her husband called to say that Diane had died. She had said her final goodbyes to her husband and son that morning and asked them to leave her alone for an hour. After an hour which must have seemed an eternity, they found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace. They asked me for advice about how to proceed. When I arrived at their house, Diane indeed seemed peaceful. Her husband and son were quiet. We talked about what a remarkable person she had been. They seemed to have no doubts

about the course she had chosen or about their cooperation, although the unfairness of her illness and the finality or her death were overwhelming to us all.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

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DECLARATION OF SAMUEL C. KLAGSBRUN, M.D.

Samuel C. Klagsbrun, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing psychiatry and I am licensed to practice medicine in the State of New York.

3. I received my medical education at the Chicago Medical School, graduating in 1962.

4. I then completed an internship at the Michael Reese Hospital in Chicago in 1963, where I received the Intern of The Year award.

5. From 1963 through 1966, I served a psychiatric residency at the Yale New Haven Hospital in New Haven, Connecticut.

6. From 1966 through 1968, I was Chief of Psychiatry at the New London Submarine Base in New London, Connecticut. During this time I also served as a Staff Psychiatrist at the New London Child Guidance Clinic and was a Clinical Instructor in Psychiatry at Yale Medical School.

7. In 1968 I began a private practice in New York City. Between 1968 and 1974 I also served in various capacities at St. Luke's Hospital in New York, New York including as Director of the Psychiatric Day Hospital (1969-71) and Director of Psychiatric Consultation Service (1971-74).

8. From 1971 thorough 1988, I served as Associate Clinical Professor in Psychiatry at the Columbia University College of Physicians and Surgeons in New York City. From 1988 to the present, I have served as a Lecturer at Columbia.

9. From 1977 to the present, I have served as Executive Medical Director at the Four Winds Hospitals located in Katonah, New York and Saratoga Springs, New York.

10. From 1975 to the present, I have been a Senior Advisor at St. Christopher's Hospice, London, England.

11. I am a member of the American Medical Association, the American Psychiatric Association, the American Group Psychotherapy Association, and the American Association of Suicidology. I am a Committee Member of the American Cancer Society Public Education Section, a Member of the Board of Directors of the New York City division of the American Cancer Society, and an Executive Committee Member of the Westchester County Mental Health Association. I have served as Chairman of the Westchester County Mental Health Association Education Committee.

12. I have published numerous articles, papers and chapters in medical journals and textbooks. Many of these address care of dying patient. My complete curriculum vitae is attached hereto as Exhibit A.

13. Throughout my career I have provided psychiatric treatment to patients dying of terminal illnesses, particularly patients dying of cancer.

14. Most cancer patients experience progressive loss of appetite, weight, and increasing pain and fatigue. As a result, they also lose their ability to care for their own needs. In addition, there are a myriad of other problems related to the specific sites of the cancer. Those with cancer of the lung, for example, experience terrible shortness of breath and coughing. Those with brain cancer often experience excruciating headaches, seizures and progressive loss of brain function.

15. Cancer usually progresses steadily and slowly over a period of months. The cancer patient is fully aware of his or her present suffering and anticipates future suffering. The terminal cancer patient faces a terrifying future. Near the end, the cancer patient is usually bedridden and experiences a rapid loss of physical and mental functions. The patient also often experiences excruciating, unrelenting pain.

16. Pain management at the end stage of cancer often requires the patient to choose between enduring unrelenting pain or sacrificing an alert mental state to the high dose of drugs adequate to alleviate the pain. Many patients will choose one or the other of these options; however, some patients do not want to end their days either wracked with pain or in a drug-induced stupor. For some patients pain cannot be managed even with aggressive use of drugs.

17. I occasionally encounter mentally competent patients who are dying of cancer, who understand their condition, diagnosis, and prognosis, and who wish to avoid prolonged suffering by hastening their deaths. For some of these patients the paramount concern is the loss of control over their destiny, the intolerable dependency on their caretakers, and the awful sense of helplessness in their daily routines. These patients either lack any means to hasten their deaths or have access only to methods that have significant risk of failure and increased anguish and pain.

18. It is my professional judgment that the decision of such a patient to shorten the period of suffering before death can be rational, and on occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death.

19. Under the statutes prohibiting assisted suicide, fulfillment of this professional responsibility might expose me to criminal prosecution. The statutes deter me from treating these patients as I believe I should.

20. The statutes prevent patients from making fundamental decisions about medical care, their lives, their suffering and their dignity. I recently had an experience, described below in detail, where, in my professional judgment a terminally ill patient of mine who desired to hasten his inevitable death was making a fully informed, rational decision and my professional judgment was that I should assist this patient in effectuating this choice; however, the statutes deterred me from doing so.

a. I once treated a patient to whom I shall refer as Ms. Jones. She was a 39-year old married woman, the mother of two children, and an accountant by profession. After being diagnosed with breast cancer, Ms. Jones underwent a mastectomy and then received radiation and chemotherapy. Ms. Jones subsequently was able to return to work on a part-time basis.

b. Ms. Jones came to me for psychotherapy, as did her husband. Her goal was to ensure that her approach to managing her illness was as sensible as possible, given the need to minimize the trauma to her children. Ms. Jones has always lived her life in a sensible and practical fashion. She had taken charge of her life by seeking sensible approaches to her problems.

c. More than a year later after she came to be in my care, notwithstanding the excellent medical care she had received for her cancer, Ms. Jones began experiencing severe and unrelenting headaches. A brain scan indicated that the cancer had metastasized to her brain. Ms. Jones underwent brain surgery to remove the tumor. She understood that her prognosis at this point was extremely poor, that there were no curative treatments, and that she was in the terminal phase of her illness. Ms. Jones began to explore alternatives, including the possibility of hastening her death should her suffering become intolerable.

d. Ms. Jones asked me if I would help her die in a painless and humane fashion by prescribing drugs she could take to hasten her death when her suffering became intolerable. I determined after extensive discussions with Ms. Jones, based on my extensive clinical experience in providing psychiatric care to terminally ill patients, that Ms. Jones's request was not caused by depression or any other mental disability. I knew that Ms. Jones was a brave, courageous woman, who was attempting to take charge of events and make an important decision by rationally considering her circum-

stances. My medical opinion was that she was asking me to help her attain a reasonable goal. However, given the current legal prohibition, I was compelled to deny her request.

e. Some months later, Ms. Jones began experiencing double vision, and it was determined that the brain cancer had spread. Still fully mentally competent, and suffering terribly, she implored me to assist her in hastening her death. I refused, and felt that I was performing a medical disservice in doing so.

f. Ms. Jones's husband called me a few days later and informed me that Ms. Jones was suffering constant nausea and intractable pain, and that she found life in this condition intolerable. Her family was devastated by having to watch her extreme suffering. Ms. Jones died several days later after further suffering.

g. At Mr. Jones's request, I treated the Jones children briefly after their mother's death. They were having emotional difficulties, not with her death, which their mother had prepared them for extremely well, but with the image of her terrible, lingering suffering at the end of her life. The image of her suffering was much more destructive to her children than her death, which they viewed as a peaceful solution to an intolerable situation.

h. I believe I failed in my duty to Ms. Jones by refusing her what I felt was an acceptable medical option for her to choose in these circumstances, *i.e.*, assistance in hastening her inevitable death in a certain and humane fashion.

i. The case of Ms. Jones is one of a number of similar cases I have experienced in my medical practice. I have witnessed these patients die in an inhumane and undignified manner after prolonged periods of extreme physical and psychological suffering. They desired to avoid

this suffering by hastening death in a humane manner, but were unable to do so.

21. The statutes prohibiting assisted suicide deter me from fulfilling my right and duty as a physician to relieve suffering and provide all the care in my professional power.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: August 31, 1994
New York, New York

/s/ SAMUEL C. KLAGSBRUN, M.D.
SAMUEL C. KLAGSBRUN, M.D.

Exhibit A

SAMUEL CHARLES KLAGSBRUN, M.D.

FOUR WINDS HOSPITAL
800 Cross River Road
Katonah, N.Y. 10536
(914) 763-8151

PERSONAL DATA

Date of Birth:	September 23, 1932
Place of Birth:	Belgium
Marital Status:	Married, one child
Citizenship:	U.S. (1946)

DEGREES, LICENSURES, CERTIFICATIONS:

1979	Fellow–American Psychiatric Association
1977	Diplomate–American Board of Psychiatry and Neurology New York State License #090545
1963-66	Psychiatric Residency–Yale New Haven Hospital
1963	Rotating Internship–Michael Reese Hospital, Chicago
1962	M.D.–Chicago Medical School
1955	B.A.–CCNY
1954	BRE–Jewish Theological Seminary

AWARDS

1963	Intern of the Year Award–Michael Reese Hospital
1954	PSI CHI (Psychology Honor Society)–CCNY
1954	Gittleson Award for Scholarship–JTS

PROFESSIONAL EXPERIENCES

1968-80	Private Practice, New York City
1966-68	Chief of Psychiatry, New London Submarine Base, Conn.
1966-68	Staff Psychiatrist, New London Child Guidance Clinic

TEACHING AND HOSPITAL POSITIONS

1977-Present	Executive Medical Director–Four Winds Hospitals, Katonah, N.Y.; Saratoga Springs, N.Y.
1975-Present	Visitor–St. Christopher's Hospice, London, England
1971-1988	Associate Clinical Professor in Psychiatry–Columbia University College of Physicians and Surgeons
1988-Present	Lecturer–Columbia University College of Physicians and Surgeons
1973-Present	Visiting Professor and Chairman–Pastoral Psychiatry, Jewish Theological Seminary
1971-74	Director–St. Luke's Hospital–Psychiatric Consultation Service
1968	Supervisor of Group Psychotherapy, St. Luke's Hospital
1969-71	Director–Psychiatric Day Hospital, St. Luke's Hospital
1968-1969	Associate Director–Psychiatric Walk-In Clinic, St. Luke's Hospital
1966-1968	Clinical Instructor in Psychiatry–Yale University School of Medicine Lecturer–Annual course on "Management of the Dying Patient" given at various New York hospitals Visiting lecturer–NYU School of Social Work

MEMBERSHIP IN ASSOCIATIONS

American Medical Association
American Psychiatric Association
American Group Psychotherapy Association
Committee Member of American Cancer Society Public Education Section
Board of Directors, NYC Division of American Cancer Society
Member of Executive Committee Thanatology Foundation
Associate Editor, Journal of Thanatology
Past Committee Member, Continuing Education, NY District Branch of APA
Chairman, Long-Term Committee, Westchester Division of APA
Member of American Association of Suicidology
Board of Directors, National Committee on Youth Suicide Prevention, NY
Executive Committee Member, Westchester County Mental Health Assoc.
Chairman, Westchester County Mental Health Association Education
Committee Board of Trustees, Westchester/Hudson Valley Chapter, Leukemia Society of America

PUBLICATIONS AND PAPERS

Klagsbrun, S.C.; *Patient, Family, and Staff Suffering*. Journal of Palliative Care 10:2/1994; 14-17.

Klagsbrun, S.C.; *Physician-Assisted Suicide: A Double Dilemma*. Journal of Pain and Symptom Management, Vol. 6, No. 5, July 1991.

Klagsbrun, S.C.; Kutscher, A.H; Bess, S; Siegel M.E.; Cherico, D.J.; Kutscher, L. G.; Peretz, D.: Selder, F. E. (Editors) *For the Bereaved: The Road to Recovery*. Philadelphia: The Charles Press, 1989.

Klagsbrun, S.C.; Kliman, Gilbert W.; Clark, Elizabeth J.; Kutscher, Austin, H.; DeBellis, Robert; Lambert, Carole A. (Editors) *Preventive Psychiatry: Early Intervention and Situational Crisis Management.* Philadelphia: The Charles Press, 1989.

Klagsbrun, S.C. *Psychosocial Aspects of Isolation in the AIDS Patient* The New york Medical Quarterly, 1988 P 10-14.

Klagsbrun, S.C.; Goldberg. I.K; Rawnsley, M.D.; Kutscher, A.H.; Marcus, E.R.; Siegel, M.E. (Editors): *Psychiatric Aspects of Terminal Illness* Philadelphia: The Charles Press, 1988.

Klagsbrun, S.C.; Reibel, J.S.; Piercey, M.C. *Cost Effective Tertiary Care* Psychiatric Clinics of North America, 1987.

Network of Trust Can Help Prevent Teenage Suicide, Atlanta Journal, March 22, 1987.

DeBellis, R; Kutscher, A.H.; Goldberg, M.R; Cherico, D.J.; Klagsbrun S.C.; and Pritchard, E.R. (Editors): *Continuing Care: For the Dying Patient, Family and Staff.* New York: Praeger Publishers, 1985 176 pp.

Margolis, O.S.; Raether, H.C.; Kutscher, A.H.; Klagsbrun, S.C.; Marcus, E.R.; Pine, V.R.; and Cherico, D.J. (Editors): *Loss, Grief, and Bereavement: A Guide for Counseling.* New York: Praeger Publishers, 1985, 155 pp.

Klagsbrun, S.C. *The Making of a Cancer Psychotherapist.* Journal of Psychosocial Oncology, 1983, Winter Vol. 1(14) P 55-60.

Kutscher, A.H.; Klagsbrun, S.C.; Torpie, R.J.; DeBellis, R.; Hale, M.S. and Tallmer, M. (Editors): *Hospice U.S.A.* New York: Columbia University Press, 1983, 304 pp.

The Politics of Expanding Hospice Care, Part 1, No. 4, and A Psychiatric Setting and Total Care, Part VI, No. 26, in Kutscher, A. and Kutscher, L. (Editors): Hospice U.S.A., New York: Columbia University Press, 1983.

Klagsbrun, S.C. *Ethics in Hospice Care* American Psychologist, Vol. 37, No.11, P 1263-1265, November 1982.

Klagsbrun, S.C. *The Management of the Dying Patient and Death* pp. 447-460, from Psychiatric Management for Medical Practitioners Edited by Donald Kornfeld and Jerry Finkel. New York: Grune & Stratton, 1982.

Kutscher, A.H.; Peretz, D.; Klagsbrun, S.C.; Cherico, D.J. and Kutscher, L.G. (Editors): *For Those Bereaved—But Not to Lose: A Book of Comfort* (revised edition). New York: Arno Press/New York Times Company, 1980, 331 pp.

Totality of Care from Birth to Death, in Pritchard, E., et al (Editors): Home Care—Living With Dying. New York, Columbia University Press, 1979.

Chapter in Kutscher, et al (Editors): *Dialogues—The Living and the Dying.* New York: Arrow Press, 1978.

Klagsbrun, S.C. *Breast Cancer, Confronting One's Changed Image. Don't Make Nice, Make Real.* American Journal of Nursing, September 1977, 77(9), P 1432.

Chaplains Who Can't Hear Published lecture Annual Meeting of Episcopal Hospital Chaplains, March 12 1973, Atlanta, GA Institute of Religion and Medicine, Chicago, IL

Kaufman, E., Klagsbrun, S.C. *An Emergency Room Changes: (Impact of Psychiatric Walk-In Clinic on Emergency Room of General Hospital)* Diseases of the Nervous System, April 1972, 33(4), P 231-234.

Klagsbrun, S.C. *Communications in the Treatment of Cancer* Kango-Gijutsu, September 1971, 17(9), P 90-98

Klagsbrun, S.C. *Communications in the Treatment of Cancer* American Journal of Nursing, May 1971, 71(5), P 944-948.

Klagsbrun, S.C. *Cancer, Emotions and Nurses* Del-Med-Journal, May 1970, P 117-120.

Klagsbrun, S.C. *Cancer, Emotions and Nurses* RN, January 1970, 33(1) P 46-51.

Klagsbrun, S.C. *Cancer, Emotions and Nurses* American Journal of Psychiatry, March 1970, 126(9), P 1237-44.

Klagsbrun, S.C. *An Analysis of Groups That Never Were* International Journal of Group Psychotherapy, April 1969, 19(2), P 142-149.

Klagsbrun, Francine and Klagsbrun, Samuel *Your Health: Nutrition* New York, Watts, 1969.

Rehabilitation in Cancer: The Psychiatric Viewpoint Published proceedings of the Symposium on Rehabilitation and Cancer. American Cancer Society, November 20, 1969.

Klagsbrun, S.C. *In Search of an Identity* Arch-Gen-Psychiatry, March 1967, 16(3), P 286-289.

Klagsbrun, S.C. *The Effects of Bias on Clinical Judgement* Chicago Medical School Quarterly, Spring 1962, 22: P 114-118.

LECTURES

Visiting Nurses Service, "Truth Telling in Hospice," June 10, 1993

Home Care Association of New York State, "Ethics in Home Care," May 10, 1993

White Plains Hospital, "Terminal Illness and Assisted Death," May 5, 1993

Middletown Psychiatric Center, "Domestic Violence—Psychiatric Aspects," April 14, 1993

Albert Einstein College of Medicine, Grand Rounds, "Cancer and Emotions," April 30, 1993

YM and YWHA of Mid-Westchester, "Understanding the Jewish Battered Woman's Dilemma," March 18, 1993

American Academy of Psychiatry and the Law, "Physician Assisted Suicide," January 23, 1993

The New York Conference of the Elie Wiesel Foundation for Humanity, Presentation and Chair: Health, Family, & Poverty, November 16, 1993

University of Connecticut, "Socio-Psychological Conflicts in Modern Jewish Life," November 15, 1992

Four Winds Hospital/Saratoga, "Psychiatric Issues In Treatment of Cancer Patients," October 2, 1992

Metropolitan Hospital, "Recovery and Resentment in Addiction," September 25, 1992

New York Medical College, "Recovery and Resentment in Addiction," September 24, 1992

New York Ethical Culture Society, "Loss, A Time For Growth," March 13, 1992.

Cancer Care, "Suicide and the Cancer Patient," December 12, 1991

National Association of Psychiatric Treatment Centers for Children, "The Need for Inpatient Care," November 21, 1991

Putnam Hospital, "Parenting Adolescents in the 90's," November 19, 1991

American Cancer Society, "Cancer Survivors in 1990's," November 13, 1991

Westchester Coalition of Family Violence Agencies, "What You Don't Know About Domestic Violence Could Kill Your Client, Therapeutic Techniques and Legal Remedies," October 30, 1991

Central Labor Rehab Council of New York, "Denial," October 22, 1991

Alliance for the Mentally Ill in Ulster County (AMI), "Must Life be Measured by the Dollar: Fighting for the Severely Ill," October 9, 1991

Columbia Presbyterian, "Terminally Ill Patients," September 25, 1991

Behavioral Healthcare Conference, Boston, "Long-Term Psychiatric Hospitalization," September 5, 1991

Westchester County Medical Center, Randy Polk Endowment Lecture, "Relationship Between Health Care Professionals and Seriously Ill Patients in the 90's: Is It At Risk?," June 6, 1991

Westchester County Medical Center, Randy Polk Endowment Lecture, "Assisted Suicide: A Problem for Modern Medicine," May 24, 1991

APA, Workshop: The Psychiatrist and the Dying Patient; Paper. "When Religious Behavior is a Symptom," May 14-16, 1991

BOCES, West County, "Balancing Stress and Excellence: The Adolescent's Challenge," May 9, 1991

MHA Benefit, Keynote Address, May 8, 1991

New York Center for Recovery, Lecture to counselors receiving substance abuse training, May 2, 1991

Columbia Presbyterian, "Dying Patient," May 1, 1991

Hofstra University Conference, "The Legal Profession in the 1990's: Is a Life in the Law Getting Better or Worse?," Panel on "The Psychological Tensions of Professional Life," April 19, 1991

Bergen Pines County Hospital, "The Sandwich Generation: Caught Between Children and Aging Parents," March 28, 1991

Jewish Theological Seminary, "Substance Abuse, Suicide, Mental Health and the Role of the Rabbi and Hazzan," February 21, 1991

Albany Medical Center, "Physician Assisted Suicide: Moral or Immoral?," January 23, 1991

Pace University Law School, "Does Religion Interfere with Mental Health?," January 9, 1991

RESEARCH INTERESTS:

Psychosomatic medicine with emphasis on the correlation between emotions and cancer. Adolescent Suicide

Battered Women Syndrome

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
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One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF HOWARD A. GROSSMAN, M.D.

Howard A. Grossman, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor specializing in Internal Medicine. Approximately 50 percent of my patients are infected with the Human Immunodeficiency Virus ("HIV").

3. I received my medical education at the State University of New York at Downstate School of Medicine in Brooklyn, New York, graduating in 1983.

4. From 1983 through 1986, I served a residency in Internal Medicine at the Kings County Hospital Center in Brooklyn, New York.

5. In 1987 I served as an Attending Physician in the Spellman Center for the Treatment of HIV-related Diseases at St. Clare's Hospital in New York City.

6. From 1987 through 1988, I served as Attending Physician in the Department of Medicine at the Bellevue Medical Center's Community Health Project, a satellite clinic designed to identify and treat those at high risk for HIV-related diseases.

7. From 1987 through 1990, I also served as Attending Physician at St. Clare's Hospital in New York City.

8. At present I am in private practice and serve as Attending Physician at St. Luke's/Roosevelt Hospital and St. Vincent's Hospital in New York City.

9. I have been involved with numerous research projects relating to treatment of persons infected with HIV and have lectured extensively regarding treatment of people with Acquired Immune Deficiency Syndrome ("AIDS").

10. I serve on the Board of Directors of the Gay Men's Health Crisis. I am a member of the AIDS Task Force of the

New York County Medical Society; the Physicians Advisory Committee to the Community Research Initiative on AIDS; the American College of Physicians; and the New York State/County Medical Society. I am a Board Member of the American Association of Physicians for Human Rights and past President of New York Physicians for Human Rights. I served on the former Scientific Advisory Board for Treatment Directory of the American Foundation for AIDS Research.

11. I am certified by the American Board of Internal Medicine and am a Diplomate of the National Board of Medical Examiners. My complete curriculum vitae is attached hereto as Exhibit A.

12. HIV infection produces a progressive destruction of the immune system, leading to AIDS, which is inevitably fatal. Persons with AIDS are vulnerable to a variety of unusual infections, cancers, and other syndromes such as wasting (chronic diarrhea/weight loss), peripheral neuropathy (nerve damage causing burning or shooting pain in the limbs), and dementia (loss of cognitive function). Death is often preceded by a prolonged period of illness and debility. As medical science becomes able to prevent and treat certain AIDS-related infections, patients develop more debilitating cancers and infections for which no treatment is available.

13. Patients with AIDS may die in many different ways. Many suffer from forms of cancer commonly seen with AIDS such as aggressive, disseminated lymphoma or Kaposi's Sarcoma. These patients may die from invasion of cancer into the lungs, causing progressive difficulty breathing and ultimately death by suffocation. Many die of pneumonia, which also causes the patient to essentially suffocate. Many with wasting disease basically die of starvation and dehydration, an excruciating process that may continue for weeks. Some patients lose so much weight that they appear skeletal and suffer such ravages of malnutrition as the inability to walk, skin deterioration and hydration. Still others die as the result of any one of several types of massive infections that resist treatment.

14. Many AIDS patients who will die of the above-described causes also suffer from conditions which themselves cause extreme pain and suffering. Examples include CMV retinitis, which leads to loss of vision and eventually blindness; neuropathy, which sometimes causes pain so agonizing that it can be relieved only by a dosage of narcotics which impairs consciousness; Kaposi's Sarcoma of the skin, which can produce severe disfigurement and pain from swollen tissues and open, weeping skin lesions.

15. Medicines can palliate the dying process in many cases. The majority of the time, I am able to ameliorate the symptoms of a dying patient so that the patient can be relatively free from pain and discomfort while dying. However, in some cases, the pain, discomfort, and loss of dignity can be relieved only with drugs which render the patient unconscious; in some cases even such aggressive use of drugs does not bring relief. In my practice I have had numerous AIDS patients receiving hospice care who repeatedly express frustration at how long the process is taking, and how painful, uncomfortable, and humiliating it is. Some of these patients have made repeated requests that their dying process be hastened.

16. I occasionally encounter mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths. These patients either lack any means to hasten their deaths or have access only to methods that have significant risk of failure and increased anguish and pain.

17. It is my professional judgment that the decision of such a patient to shorten the period of suffering before inevitable death can be rational, and on rare occasion my professional obligation to relieve suffering would dictate that I assist such a patient in hastening his or her death when palliative care becomes ineffective or unacceptable if the patient so chooses.

18. Under the statutes prohibiting assisted suicide, fulfillment of this professional responsibility would expose me to criminal prosecution. The statutes deter me from treating these patients as I believe I should.

19. The statutes have resulted in patients of mine dying tortured deaths.

20. One patient of mine, whom I will call Smith, was a vibrant active designer and AIDS activist who did not want to endure wasting and dementia before he died. While fully mentally competent and unquestionably in the end stage of AIDS, he requested my assistance in hastening his death, which I could not provide. This patient soon began experiencing a process of severe wasting, skin deterioration, chronic vomiting and, ultimately, dementia. He became disoriented and confused and unable to care for himself. The process continued for approximately six weeks before Smith died.

21. Such a prolonged dying period is inhumane to the patient, who must suffer against his wishes, and to the loved ones, who frequently express the belief that "we are kinder to our pets than we are to the terminally ill." After death, the survivors express guilt about the suffering their loved one endured, and the doctor feels remorse that the patient's suffering could not have been curtailed.

22. I have known AIDS patients who committed suicide relatively early in the course of the disease, apparently because of the fear that a death like that of patient Smith would be their fate. These individuals prematurely end their lives because they feel unable to discuss their fears with me and anticipate a death preceded by unrelieved suffering. As a physician, I have wished that I could have prevented their premature deaths by committing to help them through the subsequent stages of their illness, including, if they choose at the time, to hasten their deaths.

23. I also have known AIDS patients who attempt to commit suicide and fail. Often the failed attempt results in increased anguish and physical disability.

24. One of my current patients is plaintiff William A. Barth, who is known by his nickname "Willy." I have treated Willy regularly since 1989 and know him well. Currently we are pursuing an aggressive course of therapy to control his disease. In my medical judgment, Willy is mentally competent and should be able to request and receive my assistance in dying when his suffering becomes intolerable to him. Based on my extensive clinical experience in treating patients dying of AIDS, I have no question that Willy's condition is terminal, and that he will suffer severe pain and physical deterioration in the future. This will occur despite the availability of hospice care and aggressive pain management. Willy's decision whether or not to exercise a choice to hasten his death would be based on a full understanding of his condition, prognosis and medical care options.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 1, 1994
New York, New York

/s/ HOWARD A. GROSSMAN, M.D.
HOWARD A. GROSSMAN, M.D.

HOWARD A. GROSSMAN, M.D.
Internal Medicine
285 West 11th Street, Suite 1-W
New York, New York 10014
Telephone (212) 929-2629

Prepared November 1, 1993

PERSONAL DATA

Birthdate April 20, 1954
Birthplace Newark, New Jersey

EDUCATION AND POST-GRADUATE TRAINING

1983–1986 KINGS COUNTY HOSPITAL CENTER
Resident, Internal Medicine
Department of Medicine,
451 Clarkson Avenue, Brooklyn, NY 11203

1979–1983 SUNY-DOWNSTATE SCHOOL OF MEDICINE,
Brooklyn, NY
M.D., received May, 1983

1976–1978 COLUMBIA UNIVERSITY, NY, NY
School of General Studies,
post-baccalaureate pre-medical program

1972–1976 HAVERFORD COLLEGE, Haverford, PA
B.A., political science, received May, 1976

CERTIFICATION AND LICENSURE

American Board of Internal Medicine Certification—September, 1988

Diplomate of the National Board of Medical Examiners—July, 1986

New York State license number 162479-1,
expires December 31, 1994

DEA number BG0615700

PROFESSIONAL SOCIETIES

American College of Physicians, member

New York State/County Medical Society

New York Physicians for Human Rights, President

American Association of Physicians for Human Rights, board member

PROFESSIONAL APPOINTMENTS

St. Luke's/Roosevelt Hospital,
428 West 59th Street, NY, NY 10019

St. Vincent's Hospital,
130 West 12th Street, NY, NY 10014

WORK EXPERIENCE

Present PRIVATE PRACTICE, INTERNAL MEDICINE at 285 West 11th Street, NY, NY 10014

ATTENDING PHYSICIAN,
St. Luke's/Roosevelt Hospital
and St. Vincent's Hospital

1987, Jan. to April, 1990 ATTENDING PHYSICIAN,
St. Clare's Hospital, 415 West 51st Street, NY, NY 10019

1987, Nov. to May, 1988 BELLEVUE MEDICAL CENTER,
New York, NY
Attending physician in the Department of Medicine, working at the COMMUNITY HEALTH PROJECT, a satellite clinic designed to identify and treat those at high risk for HIV-related diseases.

1987, Jan.–Sept. ST. CLARE'S HOSPITAL, New York, NY
Attending physician in the Spellman Center for the Treatment of HIV-related

Diseases, with responsibilities for inpatient and outpatient care at one of the nation's first dedicated units for HIV care.

1986, July-Dec. VETERANS ADMINISTRATION MEDICAL CENTER Brooklyn, NY
Attending Physician, Emergency Room

1978–1979 ALBERT EINSTEIN COLLEGE OF MEDICINE, Bronx, NY
Research technician, Departments of Hematology, Genetics and Parasitology

TEACHING EXPERIENCE

College of Physicians and Surgeons, Clinical Clerkship in Medicine, Course M7201, November 4–December 13, 1991

RESEARCH EXPERIENCE

"Double-Blind Study of Timunox™ (Thymopentin) in HIV-Infected Subjects," Immunobiology Research Institute, Protocol .07.32.027-92

"Open-Label Treatment With Timunox™ in HIV-Infected Patients," Immunobiology Research Institute, Protocol .07.32.008-89

"Immunobiology and Endocrine Parameters in HIV-Infected Patients," Immunobiology Research Institute, Protocol .07.30.020-92

"A Randomized Blinded Evaluation of Two Doses of Stavudine™ (2',3'-Didehydro-3'Deoxythymidine, d4T) To Make Treatment Available to Severely Immunocompromised Patients With HIV Infection Who Have Failed or are Intolerant of Alternative Antiretroviral Therapy," Bristol Myers Protocol AI455-900

"Rifabutin Therapy for the Prevention of Mycobacterium Avium Complex (MAC) in HIV-Positive Patients with CD4

Counts Less Than or Equal to 200," Adria Laboratories Treatment IND # 087085

"Open Label Oral 566C80 for the Treatment of Patients with Severe PCP Who Are Intolerant and/or Unresponsive to Therapy with Trimethoprim/Sulfamethoxaole and Parenteral Pentamidine," Burroughs Wellcome Treatment IND # 33384-10

"An Open Label Safety Study of ddC in Patients with AIDS or Advanced ARC Who Cannot Be Maintained on Zidovudine (ZDV) Therapy," Hoffman-LaRoche Protocol N3544, completed

"Treatment Program for Anemia in AIDS Patients," Ortho Biotech Protocol I88-083, completed

Treatment IND for Foscavir, Astra Treatment IND #029466, completed

"A Treatment IND Protocol for the Use of Videx™ (2',3'-Dideoxyinosine, ddI) in Patients with Acquired Immunodeficiency Syndrome (AIDS) or AIDS Related Complex (ARC) Who Are Intolerant to Zidovudine (Retrovir™)," Bristol Myers Protocol 454-999-001, completed

"An Open Label Study Program of Videx™ (2',3'-Dideoxyinosine, ddI) in Patients With Acquired Immunodeficiency Syndrome (AIDS) Exhibiting Significant Deterioration While Taking Zidovudine (Retrovir™)," Bristol Myers Protocol 454-999-002, completed

COMMUNITY ACTIVITIES

Board of Directors, Gay Men's Health Crisis 1993 to present

Coordinator, Volunteer First-Aid Services, GMHC Morning Party, 1993

New York County Medical Society, AIDS Task Force, 1991 to present

Body Positive, board member, 1989-90

Community Research Initiative on AIDS, Physicians' Advisory Committee

ACT-UP, Treatment and Data Committee

Treatment Activist Group

American Foundation for AIDS Research (AMFAR) Scientific Advisory Board for Treatment Directory

Coalition for Rational Health Care, a coalition of community and labor groups organized to develop initiatives for HIV-positive health care workers

Hoffman-LaRoche Community Advisory Board on HIV

Burroughs-Wellcome Community Marketing Advisory Board

PUBLICATIONS

Roth EF, Grossman HA, Tanowitz H, Nagel R: Reticulocytes have increased amounts of reduced glutathione except when produced by acetyl phenylhydrazine Biochem Med June, 1979

LECTURE EXPERIENCE

Moderator, Body Positive of New York, Monthly Medical Update on AIDS

IV International Conference on AIDS: Impact on Management of HIV Disease, Roundtable sponsored by World Health Communications, Stockholm, Sweden, June 1988

"AIDS Treatment Team Workshop" World Health Communications, New York City, July 1988

Panelist, Physicians' Association for AIDS Care: Symposium on Clinical and Psychosocial Dimensions of HIV Infection, New York City, September 1988

Burroughs Wellcome Company Anti-viral Liaisons' Quarterly Meeting "Management of HIV Infection in Clinical Practice," February 1989

Body Positive of New York, "AZT Update," November, 1989

Gay Men's Health Crisis, Monthly research updates and volunteer training sessions, April 1989 to March, 1990

NYU Medical Center AIDS Medical Update Forum, January, 1990

Burroughs Wellcome physician speaker, January, 1990 to present

Ortho Biotech physician speaker, October, 1990 to present

Panelist, "100 Questions on HIV for the Amsterdam Conference," World Health Communications, April, 1992

"HIV Update, a Practitioner's Perspective," Food and Drug Administration District AIDS Coordinators' Conference, June, 1992

"Report on the Amsterdam AIDS Conference," Family Practice Grand Rounds, St. Joseph's Medical Center, Yonkers, NY, August 1992

"TPN: The New York Experience," Conference on Nutrition in HIV Disease, Munich, Germany, September, 1992

"Update on Antivirals and Opportunistic Infections," for the "VIII International Conference on AIDS Update: A Night of Truth and Hope," Palace Theater, New York, October, 1992

"AIDS, Past, Present, and Future," keynote address to the Maryland Chapter of the American Society for Parental and Enteral Nutrition Conference on Nutrition Support of the AIDS Patient, October, 1992

"The Role of Organized Physician Groups in HIV Care," Annual Statewide Conference on HIV/AIDS Policy, NYS Department of Health, AIDS Institute, Albany, NY, October, 1992

"Update from the IX International Conference on AIDS: Current Management of HIV," Marriott Marquis, New York, July, 1993

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
(206) 583-8888

Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF WILLIAM A. BARTH

William A. Barth declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I am 28 years old and am a former fashion editor for a major national fashion magazine. I am single and have no children. I have always enjoyed an active and independent lifestyle.

3. I was diagnosed HIV positive in April 1992. My physician is Dr. Howard A. Grossman, a plaintiff in this action. I have been a patient of Dr. Grossman's since 1989. In May 1992, I developed a Kaposi's sarcoma skin lesion. This was my first major illness associated with AIDS. I underwent radiation and chemotherapy to treat this cancer.

4. In September 1993, I was diagnosed with cytomegalovirus ("CMV") in my stomach and colon which caused severe diarrhea, fevers and wasting. My treatment for CMV required daily three hour home infusions.

5. In February 1994, I was diagnosed with microsporidiosis, a parasitic infection for which there is effectively no treatment. I have experienced significant additional wasting as a result.

6. At approximately the same time, I contracted AIDS-related pneumonia. The pneumonia's infusion therapy treatment was so extremely toxic that I vomited with each infusion.

7. In March 1994, I was diagnosed with cryptosporidiosis, a parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting. I have begun to lose bowel control due to the severe diarrhea.

8. I have also suffered from microbacterium avium, a form of tuberculosis which has caused yet additional wasting, fevers and night sweats.

9. For each of these conditions I have undergone a variety of medical treatments, each of which has had significant adverse side effects.

10. I have been unable to work since September 1993 because of my severe illness. It has been recommended that I take nightly intravenous feedings to attempt to stop the wasting. While I have tolerated some such feedings, I am unwilling to accept this for an extended period of time.

11. Since I was diagnosed HIV-positive I have received medical treatment. I believe that I have received good treatment and have benefited from it. At this point, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

12. I can no longer endure the pain and suffering associated with AIDS and I want to have drugs available for the purpose of hastening my death. I want to be able to speak openly with my doctor, Howard Grossman, about intentionally hastening my death through consumption of drugs prescribed for that purpose.

13. I am mentally competent. I have no current or historical mental health problems that would impair my decision making powers regarding end of life decisions. I declare under penalty of perjury that the foregoing is true and correct to the best of my knowledge.

Dated: September 1, 1994
New York, New York

/s/ WILLIAM A. BARTH
WILLIAM A. BARTH

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

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1201 Third Avenue, 40th Floor
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(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF GEORGE A. KINGSLEY

GEORGE A. KINGSLEY declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. I am 48 years old and am the director of Systems and Operations for a major publishing company. Prior to working in the publishing business, I was employed in supervisory positions by a major domestic and international airline for over 12 years. I received my Bachelor of Arts in English, Psychology and Business Administration from the University of Illinois and hold diplomas in various managerial courses. I am single and have no children.

3. I was diagnosed HIV-positive in the late 1980s and diagnosed with AIDS in 1993. At this time I have almost no immune system function.

4. My first major illness associated with AIDS was cryptosporidiosis, a parasitic infection which caused me severe fevers and diarrhea and associated pain, suffering and exhaustion. In August 1993 I was hospitalized for approximately one month to receive treatment for this infection.

5. I also suffer from cytomegalovirus ("CMV") retinitis, an AIDS-related virus which attacks the retina and causes blindness. To date I have become almost completely blind in my left eye. I am at risk of losing my sight altogether from this condition. In November 1993 I was hospitalized for approximately two weeks to receive treatment for CMV.

6. I also suffer from toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain. In December 1993 I was hospitalized for approximately three weeks to receive treatment for this infection.

7. From August 1993 to April 1994 I was unable to work because I was severely ill very frequently. Since April 1994 I have been able to return to work on a part time basis,

although my medical condition produces extreme fatigue. I live alone and I have noticed that my ability to care for myself is rapidly diminishing.

8. Several prescribed medications that I must take daily cause constant negative side effects. I take a large daily dosage of cleocin, an antibiotic prescribed to combat the toxoplasmosis infection. As a result of taking this medication I experience painful cramping, extreme gas with bloating and a total loss of appetite. I also take daily infusions of cytovene for the cytomegalovirus retinitis condition. This medication, administered for an hour through a Hickman tube which is connected to an artery in my chest, prevents me from ever taking showers and makes simple routine functions burdensome. In addition, I inject my leg daily with neupogen to combat the deficient white cell count in my blood. The daily injection of this medication is extremely painful.

9. Since I was diagnosed HIV-positive I have sought medical treatment. I believe I have received good treatment and have benefited from it. At this point it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there is no cure for AIDS.

10. I always have believed in my ability to control my own destiny, and have made important decisions only after being guided by informed, rational thought. I value my freedom and independence above all.

11. I know what it is like to lose control over one's life because of AIDS. I have witnessed the excruciating process of dying from AIDS many times over the past several years. One of my best friends recently died after an extended period of suffering in the final stages of AIDS. This friend desired to exercise the choice of hastening his death but did not have the means to do so humanely. The sound of him crying out in pain still echoes in my memory. I could do nothing to help him and he could do nothing to help himself.

12. My informed, rational choice is that my death from AIDS, when I reach the point where there is nothing more that medical science can do to halt the advance of my disease and I am living with intolerable pain and suffering, be as swift, painless and dignified as possible. I want to be able to hasten my death in my own home, in a certain and humane way, surrounded with the people I love helping me make my passing comfortable and meaningful. I do not want my loved ones to watch me suffer needlessly.

13. I want to be able to discuss the issue of hastening my death freely and openly with my physician. It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death when and if my suffering becomes intolerable. While I understand that I could attempt to use over-the-counter drugs to hasten my death should my suffering become intolerable, I am horrified by the possibility that the drugs may not work effectively or completely but instead may cause additional and prolonged suffering. My purpose in seeking the advice of a physician is to be sure that I have the choice of hastening my death in the most humane and certain manner. However, I abhor the fact that discussing what I consider to be a humane act with my physician exposes him to criminal prosecution. My doctors have provided me with the best care possible and I would never do anything to jeopardize their ability to practice medicine.

14. I am mentally competent. I have no current or historical mental health problems that would impair my ability to make a rational decision regarding how to end my life.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: September 13, 1994
New York, New York

/s/ GEORGE A. KINGSLEY
GEORGE A. KINGSLEY

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
Seattle, Washington 98101-3099
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Carla A. Kerr (CK 5194)
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(212) 837-6000

Attorneys for Plaintiffs

AFFIDAVIT OF CARLA A. KERR, ESQ. WITH RESPECT TO JANE DOE AFFIDAVIT

CARLA A. KERR, ESQ. declares:

1. I am associated with the law firm of Hughes Hubbard & Reed which, along with Perkins Coie, is counsel for plaintiffs Timothy E. Quill, M.D., Samuel C. Klagsbrun, M.D., Howard A. Grossman, M.D., Jane Doe, George A. Kingsley, and William A. Barth in the above-captioned action. I am duly admitted to practice before this Court and am fully familiar with the facts and circumstances surrounding this action.

2. I submit this affidavit for the purpose of providing the Court with a redacted copy of the Declaration of Jane Doe, attached as Exhibit A. Plaintiff Jane Doe was a terminally ill, competent adult who died as a result of throat cancer subsequent to the commencement of this action. Ms. Doe's signature, in her true name, has been redacted from the Court's copy of the declaration to preserve her privacy. The original signed declaration is maintained in the law offices of Hughes Hubbard & Reed.

/s/ CARLA A. KERR
CARLA A. KERR

Sworn to me before this
16th day of September, 1994

/s/ BARBARA S. ADLER
Notary Public

BARBARA S. ADLER
Notary Public, State of New York
No. 31-4748551
Qualified in New York County
Commission Expires Feb. 28, 1996

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)
Received September 15, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; JANE DOE; GEORGE A. KINGSLEY; and WILLIAM A. BARTH,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,
Attorney General of the State of New York,

Defendant.

Kathryn L. Tucker
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Attorneys for Plaintiffs

DECLARATION OF JANE DOE

JANE DOE declares:

1. I am a plaintiff in this matter, am competent to testify, and do so of my own personal knowledge.

2. Jane Doe is not my real name; I use this fictitious name in this lawsuit to protect my privacy.

3. I am 76 years old and am a retired physical education instructor. I received my degree in physical education from New York University in 1939. I also hold a Masters Degree in High School Guidance Counseling, which I earned from Queens College during the 1960s while I worked and cared for my children. I am widowed and have two grown children. I have always enjoyed an active and independent lifestyle. I have been a leader in my current retirement group school program and active in civic affairs.

4. In 1988 I was diagnosed with thyroid cancer. I underwent surgery to remove my thyroid, a portion of my jugular vein, and strap muscles in my right neck. I also had a 1/4 laryngectomy, leaving my voice weak but intact. I subsequently received iodine radiation therapy.

5. For several years my cancer was in remission. However, in late 1993 I was diagnosed with a major recurrence. I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural cavity and it is painful to yawn or cough.

6. My physicians have advised me that only palliative medical options are available to me and that no curative medical options are available. My physicians have suggested that one palliative procedure would be a complete laryngectomy, the surgical lifting of my stomach, and removal of my carotid

artery. This procedure would entirely and permanently eliminate my ability to speak, and the prognosis for recovery from it would be poor.

7. Because the tumor causes extreme difficulty in swallowing, I am constantly choking on my own saliva and mucous. At this time, I can no longer swallow sufficient food to nourish myself. It was recently recommended that I have a feeding tube surgically implanted into my stomach through which to receive nutrition and hydration. In early July 1994 I had the tube implanted and have suffered serious problems as a result. I have not tolerated the tube feeding well.

8. The pain associated with this cancer is constant, especially in my neck, where the pressure and ache are continuous. I experience very sharp pain around my diaphragm each time I take deep breaths, cough, belch or yawn.

9. I take a variety of medications to manage the pain. I attempt to take enough medication so as to alleviate the pain while still retaining an alert mental state. It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state.

10. I have experienced a variety of adverse side effects with each treatment regimen, including i) terrible scarring inside my throat and neck from surgery and radioactive iodine; ii) burning and swelling in my neck, a hoarse voice and nausea from beam radiation; and iii) severe pain, vomiting, nausea and pressure associated with the tube feeding.

11. I have pursued medical treatment since the time my cancer was originally diagnosed to the present time. I believe that I have received the currently available conventional treatment and have benefited from some of it. At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

12. At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.

13. For all of my adult life I have held the belief that extending human suffering in the case of terminal illness is inhumane, uncivilized and cruel, since we have the technology to allow people to choose to die in a humane manner. I believe it is my right to die peacefully and comfortably when I am terminally ill and suffering intolerably. I believe it is partly religious freedom and partly the pursuit of liberty and happiness guaranteed me by the United States Constitution. I have always considered freedom to choose how and when to die a most important human right for the terminally ill.

14. People should not be asked against their will to suffer unnecessarily in the process of dying when medical science could provide a humane death. To withhold such choice, and the means to exercise it, from those who are suffering is to deny me my right to live and die humanely. I see it as unnecessarily cruel and inhumane to deny me this option. It also is inhumane to my loved ones, my family, to require them to watch helplessly as I am forced to endure such suffering.

15. I was able to put two of my dogs to rest when they were suffering from painful, incurable diseases and yet I do not, as a conscious and competent adult, have the freedom to opt for the same humane end to my life. This is wrong.

16. I am mentally competent. I have no current or historical mental health problems that would impair my decision-making powers regarding end-of-life decisions.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 28 day of July, 1994.

_____

A/K/A Jane Doe

[EXCERPTS]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

---

94 Civ. 5321 (TG)

TIMOTHY QUILL, *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL,

Defendant.

DEFENDANT'S MEMORANDUM OF LAW IN OPPOSITION TO MOTION FOR A PRELIMINARY INJUNCTION AND IN SUPPORT OF CROSS-MOTION FOR JUDGMENT ON THE PLEADINGS

G. OLIVER KOPPELL
Attorney General of the
State of New York
120 Broadway–24th Floor
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(212) 416-8570

MICHAEL S. POPKIN
Assistant Attorney General
Of Counsel

JAY T. WEINSTEIN
Legal Assistant

* * *

and Supp. 1994).[5] The current laws classify assisted suicide under section 125.15(3) as manslaughter in the second, instead of the first degree, and treat "promoting a suicide attempt" as a class E felony. N.Y. Penal Law § 120.30 (McKinney 1987).[6]

C. The New York Task Force on Life And The Law

The New York Task Force on Life and the Law ("Task Force"), convened in 1985 by Governor Mario Cuomo and consisting of members from diverse backgrounds and viewpoints, has conducted a study of New York's prohibition of physician-assisted suicide for the terminally ill, and recommended *against* changing the laws with respect to this conduct. The New York State Task Force On Life And The Law, *When Death Is Sought: Assisted Suicide And Euthanasia In The Medical Context*, May 1994, at 117-48 (hereinafter "Task Force Report"). In the past, the Task Force's recommendations concerning the right to decide about medical treatment have been enacted into law. *See* New York Public Health Law

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5 The New York State Court of Appeals recently held that an individual who aids or urges another to a successful suicide can also be found guilty of second degree manslaughter under N.Y. Penal Law § 125.15 (1), for recklessly causing another's death. *People v. Duffy*, 79 N.Y.2d 611, ___ N.Y.S.2d ___ (1992).

6 The Temporary State Commission on Revision of the Penal Law and Criminal Code, which, in 1965, introduced to the legislature the current form of New York's penal law, removed the "more sympathetic cases" of assisted suicide from the ambit of "murder," and placed within the category of second degree manslaughter instances of "assistance rendered at the request of a person tortured by painful disease." Temporary State Commission on Revision of the Penal Law and Criminal Code, Proposed New York Penal Law to the Legis. Session of 1964, at 339 (1964). The practice commentary to the current re-enactment of the penal law in fact includes a hypothetical of assisted suicide that would constitute second degree manslaughter: "a man who, upon the plea of his incurably ill wife, brings her a lethal drug in order to aid her in ending a tortuous existence . . ." Practice Commentary to N.Y. Penal Law § 125.15(3) (McKinney 1975) (by A. Hechtman).

Articles 29-B (Orders Not To Resuscitate) and 29-C (Health Care Agents and Proxies). *See* Task Force Report at vii. The Task Fore compiled extensive data regarding suicide and the terminally ill.

The Task Force found that allowing physician-assisted suicide or euthanasia[7] would expose significant segments of the population, especially those already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group, to "extraordinary risks." Task Force Report, Preface at vii-viii, and Ch. 6. It noted the statistical correlation between requests for assisted suicide and depression, as well as requests for assisted suicide and poorly controlled pain, and concluded that allowing assisted suicide would result in an increased number of suicides in individuals in both these categories suffering from treatable symptoms. *Id.* Other individuals, such as those who felt that they were a burden on their families, would also be likely to choose suicide. The Task Force recognized that suicide advocates posited ideal cases in which none of these conditions were present, and in which the physicians had long term relationships with their patients, but found that these ideal cases

* * *

[7] Physicians assist another in committing suicide when, for example, they provide a patient with a lethal dose of pills which the patient then self-administers. By contrast, euthanasia occurs when physicians themselves administer the lethal drug, an act of murder. *See* N.Y. Penal Law § 125.25(1). *See also*, Report of N.Y. Task Force, at 63-64. As numerous commentators have noted, the line between assisted suicide and euthanasia is far from bright.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Received October 12, 1994

TIMOTHY QUILL, *et al.*,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,

Defendant.

NOTICE OF CROSS-MOTION FOR JUDGMENT ON THE PLEADINGS

PLEASE TAKE NOTICE that, upon all the pleadings and proceedings in this matter, defendants will move this Court, before the Honorable Thomas P. Griesa, United States District Judge, at the Courthouse, Foley Square, New York, New York, on October 14, 1994 at 10:30 in the forenoon, or as soon thereafter as counsel may be heard, for an Order pursuant to Rule 12(c) of the Federal Rules of Civil Procedure granting them judgment on the pleadings, for the reasons set

forth in defendants' Memorandum of Law of even date with this cross-motion.

Dated: October 7, 1994

G. OLIVER KOPPELL
Attorney General of the State
of New York,

By: /s/ MICHAEL S. POPKIN
MICHAEL S. POPKIN (MP 3209)
SUSAN L. WATSON (SW 0023)
Assistant Attorneys General
Of Counsel
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D. HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants,

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Attorneys for Plaintiffs

SUPPLEMENTAL DECLARATION OF TIMOTHY E. QUILL, M.D.

Timothy E. Quill, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this supplemental declaration in further support of plaintiffs' motion for a preliminary injunction and, to make clear the medical treatment that I seek to be able to give my patients.

3. I bring this action in order to be able to fulfill my professional obligations to my mentally competent, terminally ill patients who seek my assistance in hastening their deaths. I seek the right to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients tc self-administer at the time and place of their choice for the purpose of hastening their impending deaths.

4. The proposition that the withdrawal of medical treatment does not require full, conscious and active participation by the terminally ill patient's doctor is not accurate. The removal of a life support system that directly results in the patient's death requires the direct involvement by the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment. It is legally and ethically permitted for physicians to actively assist patients to die who are dependent on life-sustaining treatments.

5. For example, sometimes patients with lung cancer or other terminal respiratory diseases are put on respirators (breathing machines) in an effort to prolong their life. Some of these patients decide that they no longer want to go on living if they must remain on such machines to breathe, or because other aspects of their suffering have become intolerable. Once they are fully informed of their alternatives, and are sure that they want the respirator removed even if it will result in their death, they then have the right to have the treatment discontinued. At a practical level, the doctor must take several actions to carry out the patient's desire. The doctor must turn off the breathing machine, disconnect the machine from the tube that goes to the patient's lungs, and then remove the tube from the patient's lungs. Since dying of respiratory failure can be one of the most excruciating and frightening deaths possible, the doctor usually must also give morphine or barbiturates to ameliorate the patient's sensation of suffocation. These patients must be carefully monitored after the respirator is withdrawn, for sometimes the symptoms of severe air hunger reemerge in spite of continuous infusions of morphine or barbiturates. These medications must often be used in doses that contribute to the patient's death by suppressing their respiratory drive. Such patients can linger for days or even weeks in a twilight state, with fluctuating levels of mental alertness and of air hunger, before eventually dying. The removal of a mechanical ventilator requires active participation and ongoing monitoring by the doctor and other members of the health care team. In spite of everyone's best efforts, it can result in a wrenching experience for the patient, the patient's family and medical personnel.

6. Some dying patients are dependent on feeding tubes or intravenous lines to provide hydration and nutrition. These patients have the right to refuse this treatment even when it will result in their death. Though some patients find discontinuing hydration and nutrition an acceptable way to die, others experience the subsequent process of gradually dehydrating, starving, and passing into an unconscious, completely dependent and helpless state both humiliating and unacceptable. The process generally takes seven to ten days, though it may take much longer if the patient takes sips of any kind of liquids. The patient gradually loses control of his or her men-

tal and physical capacities, and becomes totally dependent on medical personnel and family to care for even the most basic bodily functions. The patient's kidneys and liver eventually fail, allowing the accumulation of toxins that gradually cloud consciousness, and eventually result in the patient's death. As patients pass through this process, they continue to need the active involvement of their physicians and other medical personnel. Patients whose organs are failing may experience hallucinations, fear and confusion. Such symptoms must be treated, often with sedatives that may hasten the patient's death. Under these circumstances, sedatives must be used because doctors must not let their dying patients linger in a nightmarish condition that can only end in their death. While death from dehydration and starvation is acceptable to some of our patients, others ask us why they must endure such an ordeal when it can only end in their death, especially when there are alternatives available that could ease death more humanely.

7. Though deaths such as those described above have been characterized as "natural," they actually involve the active participation of doctors throughout the process, often including medical interventions that contribute to an earlier death. As the clinical descriptions suggest, these processes are often not an easy way out. Yet, at least these patients who are dependent on life-sustaining treatment are allowed to have a legitimate, open discussion with their physician about choosing death as preferable to life under the circumstances they are forced to live, and their physicians are allowed to actively and openly assist them to die without fear of legal repercussions. Unfortunately, some dying patients who are in agony that can no longer be relieved, yet are not dependent on life-sustaining treatment, have no such options under current legal restrictions. It seems unfair, discriminatory, and inhumane to deprive some dying patients of such vital choices because of arbitrary elements of their condition which determine whether they are on life-sustaining treatment that can be stopped.

These patients are asking us, and at times begging us, for the same choice.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
New York, New York

/s/ TIMOTHY E. QUILL, M.D.
TIMOTHY E. QUILL, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

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New York, New York 10004
(212) 837-6000

Attorneys for Plaintiffs

SUPPLEMENTAL DECLARATION OF SAMUEL C. KLAGSBRUN, M. D.

Samuel C. Klagsbrun, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this supplemental declaration in further support of plaintiffs' motion for a preliminary injunction and to make clear the medical treatment that I seek to be able to give my patients.

3. I bring this action in order to be able to fulfill my professional obligations to my mentally competent, terminally ill patients who seek my assistance in hastening their deaths. I seek the right to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients to self-administer at the time and place of their choice for the purpose of hastening their impending deaths.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
New York, New York

/s/ SAMUEL C. KLAGSBRUN, M.D.
SAMUEL C. KLAGSBRUN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

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1201 Third Avenue, 40th Floor
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Attorneys for Plaintiffs

SUPPLEMENTAL DECLARATION OF HOWARD A. GROSSMAN, M. D.

Howard A. Grossman, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this supplemental declaration in further support of plaintiffs' motion for a preliminary injunction and, to make clear the medical treatment that I seek to be able to give my patients.

3. I bring this action in order to be able to fulfill my professional obligations to my mentally competent, terminally ill patients who seek my assistance in hastening their deaths. I seek the right to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients to self-administer at the time and place of their choice for the purpose of hastening their impending deaths.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
New York, New York

/s/ HOWARD A. GROSSMAN, M.D.
HOWARD A. GROSSMAN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker (KT9200)
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HUGHES HUBBARD & REED
One Battery Park Plaza
New York, New York 10004
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Attorneys for Plaintiffs

DECLARATION OF JACK FROOM, M. D.

Jack Froom, M.D. declares:

1. I am competent to testify and do so of my own personal knowledge.

2. I am a medical doctor and received my medical degree from the University of Illinois in 1946.

3. My specialty is Family Practice. I am certified by the American Board of Family Practice and have over 20 years experience practicing medicine in a clinical setting as a family physician. I am also a Professor of Family Medicine and have over 20 years of teaching experience in that field. I am presently Professor at the State University of New York at Stony Brook. From 1978 through 1991 I was the Director of Family Medicine Research at this University.

4. I serve on the editorial advisory board or am manuscript consultant to numerous medical journals including: Family Practice: An International Journal; Annals Of Internal Medicine; Pediatrics; Journal of American Diseases of Children; Journal of the American Board of Family Practice; Journal of Family Practice; Family Medicine; and Archives of General Psychiatry.

5. I hold hospital appointment privileges and am a Senior Attending Physician at University Hospital, Stony Brook, New York.

6. I have published over 80 articles related to the practice of Family Medicine in medical journals. I have also authored numerous books, book chapters and monographs in the field.

7. I have substantial experience and have conducted research and published in the area of detecting depression in primary care patients. Of particular relevance here are "Detection of Major Depressive Disorder in Primary Care Patients," 6 *Journal American Board of Family Practice* 5

(1993), "The Inventory to Diagnose Depression (IDD) in Primary Care Patients," 10 *Family Practice* 312 (1993).

8. My complete curriculum vitae is attached hereto.

9. In my nearly 50 years experience as a practicing family physician and medical educator, I have had many occasions to witness mentally competent, terminally ill adult patients confront issues relating to their dying process, including the issue of hastening the dying process. Over this period, I have also seen many patients endure unnecessarily prolonged pain and suffering in the dying process under circumstances where patients, for one reason or another, had insufficient participation in deciding upon their terminal care.

10. Physicians caring for patients with terminal illnesses necessarily become directly involved in assisting such patients and their families to understand the prognosis, expected course and options for either therapeutic or palliative care. In the presence of terminal illness, the shared goal of medical care at some point becomes comfort care rather than cure. The physician's task becomes one of alleviating pain and suffering as much as possible.

11. With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt. As a result, many experience prolonged deaths often involving pain, suffering and loss of dignity. In reaction to this problem, an increasing number of patients want more direct control over the type of care they receive in the last stage of their lives. A subset of dying patients desire to shorten their dying process and thereby avoid a lingering death and associated pain, suffering and loss of dignity.

12. The desire of a patient to shorten the dying process is not necessarily indicative of depression or any other form of mental illness or instability. This choice can be entirely rational in light of a particular patient's condition, prognosis and suffering. Physicians can determine whether a patient's

request to hasten death is rational and competent or motivated by depression or other mental illness or instability. Physicians currently make these determinations as to patient capacity to make end-of-life decisions with respect to orders not to resuscitate and refusal of life-sustaining treatment.

13. Terminally ill persons who seek to hasten death by consuming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. Many terminally ill persons will be taking a variety of medications for their condition; for example, patients suffering chronic pain may be taking high doses of morphine or other narcotics and may have developed a high tolerance to narcotics. Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task.

14. Physician assistance for terminally ill patients suffering unrelievable and intolerable pain and physical decline comports with a physician's ethical obligation to alleviate needless, painful suffering.

15. It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice. These efforts are often unsuccessful and can cause the patient and family increased anxiety, pain and suffering. Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.

16. There is often a severe adverse emotional and psychological effect on terminally ill patients who either are unable to broach the subject of their desire to hasten their death with their physician because of the current prohibition or broach the subject but are rebuffed. These patients feel abandoned by their physician when most in need of help.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct to the best of my knowledge.

Executed at Stony Brook
this 8 day of October, 1994.

/s/ JACK FROOM, M.D.
JACK FROOM, M.D.

DECEMBER 1993

CURRICULUM VITAE

Jack Froom, M.D.
Professor of Family Medicine
Health Sciences Center
State University of New York at Stony Brook
Stony Brook, NY 11794

Phone: (516) 444-2300

Birthplace: Chicago, Illinois
Date of Birth: 5/17/23

Social Security Number: 335-16-3431

Married - Spouse's Name: Selma B. Froom
Year of Birth of Children: 1948, 1951, 1953, 1960

United States Military Service: Rank - Captain, Air Force
1943-1949

EDUCATION

University of Illinois - Urbana, Illinois - Premedical - B.S. Degree - 1945

University of Illinois - Chicago, Illinois - Medicine - M.D. Degree - 1946

POSTDOCTORAL TRAINING

Los Angeles County Hospital - Rotating Internship - 1946-1947

Langley Porter, San Francisco - Trainee - Psychiatry - 36 weeks - 1962

SPECIALTY BOARD

American Board of Family Practice - 1970
Recertification 1977, 1982, 1988

PRIVATE PRACTICE

1950-1971 - Petaluma, California
Past PresidentvSonoma County Heart Association
Past Chief of Staff - Sonoma County Hospital, Santa Rosa, California
Past Chief of Staff - Hillcrest Hospital - Petaluma, California
Director, Coronary Care Unit - Hillcrest Hospital - 1967-1971

UNIVERSITY OF ROCHESTER - 1971 - 1978

Assistant Professor of Family Medicine 1971 - 1974
Associate Professor of Family Medicine 1974 - 1978

STATE UNIVERSITY OF NEW YORK AT STONY BROOK
1978 - PRESENT

Professor
Vice Chairman 1978 -1991
Director of Family Medicine Research 1978 -1991

PROFESSIONAL ACTIVITIES

International

Chairman, Classification Committee - U.S. representative — World Organization of National Colleges Academies and Academic Associations of General Practitioners - Family Physicians (WONCA) 1976-1991.

WONCA Representative - ICD-10 Revision Meeting, Geneva, 1989

Chairman, Sub-committee on Standard Terminology -World Organization of National Colleges, Academies and Academic Associations of General Practitioners -Family Physicians

Coordinator - International Primary Care Network (IPCN) includes U.S.A., Canada, Australia, New Zealand, United Kingdom, Israel, Netherlands, Belgium, Switzerland

National

Former Chairman, Advisory Committee to the International Classification of Diseases — Adapted — American Hospital Association

Chairman, Committee for the Development of Glossary of Definitions of Primary Care — North American Primary Care Research Group

Member Process Coding Committee — North American Primary Care Research Group

Ad Hoc Committee to produce a Position Paper on Research in Family Medicine — Society of Teachers of Family Medicine

Board of Directors — The Ambulatory Sentinel Practice Project of North America
Board of Directors — Hames Consortium

State

Chairman, Committee of Research, Directors of New York State Family Medicine Programs 1978-1980.

Health Advisory Resources Committee — New York State Department of Correctional Services 1974-1980.

Medical Journals

Former Editor - WONCA News
Editorial Advisory Board
Family Practice: An International Journal
Manuscript Consultant:
Annals of Internal Medicine
Pediatrics
Journal of American Diseases of Children
Journal American Board of Family Practice
Journal of Family Practice
Family Medicine
Archives of General Psychiatry

Editor - in Family Practice: Selections from the Current Literature 1987 - 1991

Editor - WONCA NEWS 1987 - March 1988

Federal Agencies

Consultant to Ambulatory Care, Long-term Care, and Manpower Facilities Technical Consultant Panel of the HEW National Committee of Health and Vital Statistics

Invited participant conference on the Accuracy of Abstracted Patient Discharge Data - National Center for Health Statistics

Invited participant conference on Uniform Hospital Discharge Diagnostic Summary Coding Guidelines

National Institute of Mental Health Services Research Review Committee 1987-1991

Invited participant: National Institute of Mental Health Conference on DSM 4. July 1989, Jan 1990

Invited participant: Fourth Annual NIMH International Research Conference on Classification and Treatment of Mental Disorders in General Medical Setting June 1990

Consultant - AHCPR Panel on Depression, 1991

Stony Brook University

Professor of Family Medicine 1978 - Present

Vice Chairman Department of Family Medicine 1978-1991
Chairman Medical Records Committee, University Hospital 1981 - 1985
Director of Research, Department of Family Medicine 1978 - 1991
Chairman, AP&T Committee, Department of Family Medicine 1978 - 1991
Curriculum Committee, Medical School 1984 - 1988

Appointment, Promotion and Tenure Committee - 1990 - Present
Director, Third Year Clerkship in Family Medicine, University Hospital 1981 - 1987
Ad Hoc Committee on Use of Media, Medical School, 1981
Search Committee for Chairman, Department of Psychiatry
Search Committee for Chairman, Department of Pediatrics
Co-Teacher — Literature in Medicine
Teacher in a full range of courses including:
Lectures in 3rd year clerkship
Lectures in 2nd year systems courses
Lectures in yearly continuing education courses
Lectures in noon conferences
Monthly lectures in electrocardiography

HOSPITAL APPOINTMENT

Senior attending University Hospital, Stony Brook, New York

RESEARCH ACTIVITY - CURRENT

1. Classification and nomenclature of family/household problems
2. Otitis Media - International Comparisons
3. Computerized program for surveillance of hypertension patients
4. Diabetes Mellitus - type 2 - surveillance
5. Functional status assessment
6. Study of the process of ambulatory care
7. Depression and Seasonality in Primary Care Patients

BEST AVAILABLE COPY

PUBLICATIONS

1. *Munib HI,Froom J*: Rupture of a duodenal ulcer during cortical extract therapy for serum sickness. California State Medical Journal 94:378-379, 1962.

2. *Froom J*: Conversion to problem-oriented records in an established practice. Annals of Internal Medicine 78:254:275, 1973.

3. *Froom J, Rozzi C, Metcalfe D*: Computer Analysis of morbidity reports in primary care. Journal of Clinical Computing 2:42-51, 1973.

4. *Farley E, Treat D, Baker C, Froom J, Henck S*: An integrated system for the recording and retrieval of medical data in a primary care setting (Introduction to Series); Part 1. The age sex register. Journal of Family Practice 1:1:45–46, 1974.

5. *Froom J*: Part 2: Classification of diseases. Journal of Family Practice 1:1:47-48, May 1974.

6. *Froom J*: Part 3: Diagnostic Index-E Book. Journal of Family Practice 1:2:45-48, August 1974.

7. *Froom J*: Part 4: Family folders. Journal of Family Practice 1:2:49-51, August 1974.

8. *Froom J*: Part 6: The problem-oriented record. Journal of Family Practice 1:3/4:45-52, November/December 1974.

9. *Froom J*: Part 7: The encounter form and the minimum basic data set. Journal of Family Practice 2:1:37-41, February 1975.

10. *Froom J, Treat D, Farley E. Henck S*: A curriculum for family medicine. NY State Journal of Medicine 74:15511553, August 1974.

11. *Henk M, Froom J*: Outreach by primary care physicians. Journal of the American Medical Association 233:256-259, 1975.

12. *Froom J*: A new classification of health problems for primary care physicians (The ICHPPC) Journal of Clinical Computing 2:76-82, 1976.

13. *Froom J*: The International Classification of Health Problems for Primary Care. Medical Care: 5:459-463; May 1976.

14. *Froom J*: Assessment of quality of care by profiles of physicians' morbidity data. Journal of Family Practice Vol 3:3:301-303, 1976.

15. *Froom J*: Minimum basic data set. New York State Journal of Medicine: Vol 76:9:1541 - 1542, September 1976.

16. *Trabert NL, Froom J, et al;* Physicians prescribing patterns: I. Technical aspects and initial analyses. Drug Information Journal: April - September 1976: 84-90.

17. *Sullivan RJ, Froom J, Wood M, Williams T*: Primary care practice assessment and information systems. Johnson Foundation. December 1976.

18. *Froom J, Warren P, Mangone D, et al*: Implementation of a medical record and data system for correctional facilities. New York State Journal of Medicine. February 77:2:209-215.

19. *Froom J, Howe, Mangone D, et al*: A health data system for New York State correctional facilities. American Journal of Public Health Brief. March 1977:67:3:250-251.

20. *Froom J*: Lead screening by family physicians. Journal of Family Practice 4:4:631–633, 1977.

21. *Farley E, Treat D, Froom J, et al*: An integrated medical record and data system for primary care. (Introduction to eight-part series) Journal of Family Practice 4:5:949, 1977.

22. *Froom J*: Part 1: The age sex register: Definition of the patient population . Journal of Family Practice Vol. 4:5:951-953, 1977.

23. *Froom J*: Part 2: Classifications of health problems for use by family physicians. Journal of Family Practice Vol. 4:6:1149-1151, 1977.

24. *Froom J, Culpepper L, Boisseau V*: Part 3: The diagnostic index—manual and computer methods and applications. Journal of Family Practice Vol. 5:1:113-120, 1977.

25. *Froom J, Culpepper L, Kirkwood CR, Boisseau V, Mangone D*: Part 4: Family information. Journal of Family Practice Vol. 5:2:265-270, 1977.

26. *Farley ES,m Boisseau V, Froom J*: An integrated medical record and data system for primary care: Part 5: Implications of filing family folders by area of residence. Journal of Family Practice 5:3:427-432, 1977.

27. *Froom J*: Problem oriented medical records: A reassessment. Journal of Family Practice Vol.5:4:627-630, 1977.

28. *Froom J, Kirkwood CR,Culpepper L, Boisseau V*: An integrated medical record and data system for primary care; Part 7: The encounter form: problems and prospects for a universal type. Journal of Family Practice Vol. 5:5:845-849, 1977.

29. A Glossary for Primary Care: Report of the North American Primary Care Research Group (NAPCRG) Committee on Standard Terminology — Froom J, Chairman, Journal of Family Practice 5:4:633-638, 1977.

30. *Kirkwood CR, Froom J*: Screening during routine health assessment. Journal of Family Practice 5:4:561-566, 1977.

31. *Schneeweiss R, Stuart W, Froom J, et al*: A conversion of the *Royal College of General Practitioners Classification of Diseases Modified* for use with problem oriented medical records (RCGP) to the *International Classification of Health Problems in Primary Care* (ICHPPC). Journal of Family Practice 5:3:415-424, 1977.

32. *Howe B, Froom J, Culpepper L, et al*: Adoption of the sick role by prisoners: Report on a multifunctional experiment. Social Science and Medicine Vol. 11:507-510, 1977 Perfamon Press.

33. *Boisseau V, Froom J*: Practice profiles in evaluating the clinical experience of family medicinal trainees. Journal of Family Practice Vol. 6:801-805, 1978.

34. *Froom J, Culpepper L, Becker L, Boisseau V*: Research design in family medicine. Journal of Family Practice 7:75-90, 1978.

35. *Froom J, Boisseau V, Sherman*: Selective screening for lead poisoning in an urban teaching practice. Journal of Family Practice 9:856-70, 1979.

36. *Froom J, Boisseau V*: Benzdamine oral rinse for sore throat. Current Therapeutic Research 26:856-861, 1979.

37. *Froom J, Rosen MG*: The family in family medicine research. Journal of Medical Education 55:60-621, 1979.

38. *Jolly W, Froom J, Rosen MG*: The genogram. Journal of Family Practice Vol. 10:251-255, 1980.

39. *Froom J, Mold J, Culpepper L, Boisseau V*: The spectrum of otitis media in family practice. Journal of Family Practice 10:599-605, 1980.

40. *Boom WH, Lamberts HE, Froom J, Blondell R*: Patient and family doctor. Rochester USA, and Ommord (Netherlands) compared. (1978) Huisarts Wetenchap 21:53.

41. *Froom J*: The spectrum of urinary tract infections in family practice. Journal of Family Practice 11:385-391, 1980.

42. *Froom J, Schneeweiss R*: Use of the international classification of health problems in primary care (ICHPPC-2) for reimbursement. Journal of Family Practice 11:609-620, 1980.

43. *Culpepper L, Froom J*: Incarceration and blood pressure. Social Science and Medicine 14A:571-574, 1980.

44. Graduates of Family Practice Residency Programs in New York State. Report of a committee of directors of research of New York State Family Medicine Residency Programs. *Jack Froom, M.D.*, Chairman, Journal of Family Practice 11:753-760.

45. *Tindall HL, Culpepper L, Froom J, et al*: The NAPCRG process classification for primary care. Journal of Family Practice 12:309-318, 1981.

46. *Becker LA, Boyle RM, Froom J, et al*: A Conversion Code for ICHPPC-1 to ICHPPC-2, Journal of Family Practice 12:707-719, 1981.

47. *Froom J, Tchao P*: A curriculum in electrocardiography for family physicians. Journal of Family Practice 12:857-864, 1981.

48. *Froom J (Editor)*: An International Glossary for Primary Care. Report of the Classification Committee of the World Organization of National Colleges, Academies and Academic Associations of General Practitioner/Family Physician (WONCA). Journal of Family Practice 13:671-681, 1981. Also published in Huisarts en Wetenchap 24:342-346, 1981.

49. *Froom J, et al*: (Committee Member). Meeting the Challenge of Research in Family Medicine. Report of a study group on Family Medicine Research. Journal of Family Practice 14:105-113, 1982.

50. *Froom J*: Otitis Media. Journal of Family Practice 15:743-770, 1982.

51. *Armstrong EG, Jaffe A, Froom J, Rosen M*: Development of a clerkship curriculum in the family life cycle. Journal of Medical Education 57:872-874, 1982.

52. *Froom J*: New directions in standard terminology and classification in Primary Care. Public Health Reports 99:73-77, 1984.

53. *Froom J, Feinbloom RI, Rosen MG*: Risks of Referral. Journal of Family Practice 18:623-626, 1984.

54. *Froom J*: Diabetes Mellitus — A Review: Family Practice — An International Journal 1:52-66, 1984.

55. *Jaffe A, Armstrong EG, Robbins AC, Froom J*: A Comprehensive Clerkship in family medicine. Medical Education 18:28-32, 1984.

56. *Green LA, Wood M, Becker L, Farley ES, Freeman WL, Froom J, et al*: The ambulatory sentinel practice network: Purpose, methods and policies. Journal of Family Practice 18:275-280,1984.

57. *Froom J, Froom P*: Electrocardiogram abnormalities in primary care patients. Journal of Family Practice 18:223-225, 1984.

58. *Froom J*: Family Practice — A unique discipline., Israel Journal of Medical Sciences 20:59

59. *Reis S, Almagor G, Froom J*: Pediatric health care within the family medicine framework. Harofah 277-279 March 15, 1984 (Hebrew).

60. *Froom J*: ICHPPC-2-Defined (International Classification of Health Problems in Primary Care). Journal of Family Practice 19:129-130,

61. *Froom P, Froom J, Van Dyk D et al*: Lytic Spondylolisthesis in Helicopter Pilots Aviation, Space and Environmental Medicine. 55:556-557, 1984.

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63. *Froom J*: Headache: The effect of household Configuration (Special Feature.) Australian Family Physician 1985: 14:956-959.

64. *Schneeweiss R, Cherkin DC, Hart LG, Revicki DA, Wollstadt LJ, Stephenson MJ, Froom J, Dunn EV, Tindall HL, Rosenblatt RA:* Diagnosis Clusters Adapted for ICD-9-CM and ICHPPC-2. J Fam Pract. 1986 22:69-72.

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68. *Froom P, Froom J*: Adjusting for selection biases in referral populations. Journal of Family Practice 24:80-82, 1987.

69. Ad Hoc Working Group for Critical Appraisal of the Medical Literature (Froom J. - Members): A proposal for more informative abstracts of clinical articles. Annals of Internal Medicine 1987; 106:598-604.

70. *Froom J, Yodfat Y*: Classifying Family/Household Problems. Family Practice 1987; 4:111-113.

71. *Froom P, Gross M, Froom J, Margoliot S, Benbossat J*: Sensitivity of the high-power field method in detecting red blood cells in the urinary sediment. Israel Journal of Medical Science 1987; 23:1118-11120.

72. *Culpepper L, Froom J*: The International Primary Care Network: Purpose, Methods and Policies. Family Medicine 1988;20:191-201

73. *Froom J et al*: Diagnosis and antibiotic treatment of acute otitis media. Report from International Primary Care Network. Brit Med J 1990;300:582-6

74. *Froom J*: Glycemic control in elderly people. Clin in Geriatric Medicine. 1990; 6:933-941.

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76. *Froom J etal*: Otitis Media in day care children. J Fam Pract. 1991; 32-289-294

77. *From J, Froom P*: Prudence in disease prevention. J Clin Epidemiol. 1991;44:112-1130

78. *FroomJ,Schlager D, Stenecker S, Jaffe A*: Detection of Major Depressive Disorder in Primary Care Patients. Journal American Board of Family Practice 1993:6; 5-11.

79. *Froom P, Froom J*: Selection Bias in Using Data From One Population to Another: Common Pitfall in the Interpretation of Medical Literature. Theoretical Medicine 1992:13; 255-259.

80. *Shavartizman P, Froom J*: Need for Continuing Tuberculosis Surveillance in Previously Screened New Immigrants. Journal American Board of Family Practice 1993:6, 61-63.

81. Froom P, *Froom J*. Deficiencies is structured medical abstracts. J Clinical Epidemiol. 1993;46:591-594.

82. *Froom J*, Hermoni D. The inventory to diagnose depression (IDD) in primary care patients. Fam Pract. 1993;10:312-316.

83. Herman J, *Froom J*. Thrombolytic therapy in acute myocardial infarction; some reservations. J Clinical Epidemiol. 1993;46:1237-1241.

84. *Froom J*, Culpepper L etal. Effect of patient characteristics and disease manifestations on the outcome of acute otitis media at two months. Arch Fam Med. 1993;2:841-846.

85. Culpepper L, *Froom J etal*. Otitis media in adults. J Amer Board Fam Pract. 1993;6:333-339.

86. Becker LA, Green LA, Beufait D, Kirk J, *Froom J*. Detection of intracranial tumor, subarachnoid hemorrhage or subdural hematoma in primary care patients. J Fam Pract. 1993;37:135-141.

87. Becker LA, Green LA, Beufait D, Kirk J, *Froom J*. Use of CT scans for the investigation of headache. J Fam Pract. 1993;37:129-134.

88. Herman J, *Froom J*. Marital status and timing of coronary artery surgery. Med Hypothesis. 1994;41:459-461.

In Press

1. Tsuda T, Aoyama H, Froom J. Primary health care in Japan and the United States. Soc Sci and Med.

Submitted

1. Schlager D, *Froom J*, Jaffe A, Steneker S. Wintertime depression and functional impairment among primary care patients. Psychosomatic Medicine.
2. Jaffe A, Froom J, Galambos N. Minor depression in primary care. JAMA

Series In Family Practice

Froom J: Selections from Current Literature Family Practice

1. 1987; 4:152-154
2. 1987; 4:240-243
3. Back Pain 1987; 4:330-334
4. Diabetes Mellitus Update 1988; 5:68-74
5. Symptoms of Undetermined Etiology 1988; 5:224-228
6. Review Articles 1989; 6:70-73
7. Health Status Assessment 1989; 6:153-156
8. The Cholesterol Controversy 1989; 6:232-237
9. Fibrositis. 1989; 6:316-319
10. Euthanasia. 1991; 8: 100-104
11. Hormone Therapy in Postmenopausal Women. 1991;8:288-292.

PUBLISHED PROCEEDINGS

1. *Froom J*: Design of Curriculum based on morbidity data. Society of Teachers of Family Medicine, Washington, D.C. 1973.
2. *Treat D, Froom J*: The International Classification of Health Problems in Primary Care. Proceedings of the Fourth Annual Conference of the Society for Computer Medicine, New Orleans, Louisiana, November 7-10, 1974.
3. *Froom J*: Quality of Care Assessment by Profiles of Physicians' Morbidity and Prescription Data. Delivered at the World Organization of National Colleges and Academies of General Practice/Family Medicine - November 6, 1974, Mexico City.
4. *Froom J*: Practice Profiles in the Family Practice Center - Computer Method. Annual Workshop for Directors of Family Practice Residencies - American Academy of Family Physicians, June 1975, Kansas City, Missouri.
5. *Froom J*: The International Classification of Health Problems for Primary Care-Cornerstone of an Ambulatory Data Set. Delivered at the Fifth Annual Conference of the Society for Computer Medicine, Chicago, Illinois, November 12-14, 1975.
6. *Jolly W, Froom J, Rosen M*: The Genogram in Primary Care Research in 1980. Ed. Lipkin J, White KL.

BOOKS

1. Lipkin M, Bufford J, Froom J, White KL: Primary Care Research in 1981. The Rockefeller Foundation.
2. Lipkin M, Bufford J, Froom J, Schonberg K, White KL: Primary Care Research in 1982. New York University.
3. Lipkin M, Bufford J, Froom J, et al: Primary Care Research in 1983. New York University Press 1984.

4. Froom J: Non-Insulin-Dependent Diabetes Mellitus. Saunders - Primary Care 1988.
5. Froom J: Diabetes Mellitus in Elderly Patients. Saunders. Clinics in Geriatric Medicine - Due Nov. 1990
6. WONCA Classification Committee. J. Froom, Chairman Functional Status Measurement in Primary Care - Springer Verlag - 1990

Chapters

1. Chronic Childhood Illness, Assessment of Outcome. Grave GD, and Pless IB (eds.): Fogarty International Center Series on the Teaching of Preventive Medicine; DHEW Publication No., (NIH)-76-876, Washington, D.C. 1976.
2. Acute Back Pain - Passive Treatment in Common Dilemmas in Family Medicine by John Fry. George A. Bogden & Son, New Jersey, 1983.
3. Classification Systems in Family Medicine by Robert B. Taylor. Springer Verlag - New York 1983.

Contributions to Classifications

1. ICHPPC - World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians. American Hospital Association 1975. Froom - U.S. Representative.
2. ICHPPC-2 World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA). Oxford Medical Publications 1979. J Froom-Chairman
3. I.C.D.-9-CM - J Froom representing the Society of Teachers of Family Medicine.
4. H.I.C.D.A.-2-J Froom representing the Society of Teachers of Family Medicine.

5. ICHPPC-2 Defined. Oxford University Press. Report of Classification Committee. World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians 1983. Jack Froom - Chairman.
6. NAPCRG-1. A Process Code for Primary Care: Ad-hoc Committee for Process Coding: North American Primary Care Research Group. Richmond Virginia 1981.
7. International Classification of Process in Primary Care-Produced by the International Classification Committee (*Jack Froom, Chairman*) of W.O.N.C.A. Oxford University Press 1986.
8. Froom J: Forward to International Classification of Primary Care (Ed.) Lamberts H, Wood, M. Oxford University Press 1987.

BOOK REVIEWS

1. Froom J, Lawrence Duane A: Review of article entitled Feinstein, AR, "The problems of the problem oriented record," Ann Intern Med 78: 151-162, 1973 for selected references in Family Medicine, Second Edition, 1975.
2. Froom J: An inventory for primary health care practice by Archie S. Golden, 146 pages. Ballinger Publishing Company, Cambridge, Mass., 1976. Review appeared in Annals of Internal Medicine: 87:1:134, July 1977.
3. Froom J: the Physician's Practice - Ed John M. Eisenberg, et al. Wiley and Sons 1980. Annals of Internal Medicine 94:715, 1981.

EDITORIALS

1. Froom J: Classification of health problems for primary care. Medical Record News 45:6-6-11, October 1974.

2. Froom J: International Classification of Health Problems in Primary Care. JAMA 234:1257 1258, 1975.

3. Froom J: ICHPPC-2-An improved classification system for family practice. J Fam Pract 10:791-792, 1980.

4. Froom J: Chronic disease surveillance. J Fam Pract 23:3111-312, 1986.

5. Froom J: ICHPPC-2 An improved classification system for family practice. Journal of Family Practice 10:791-792

6 Froom J: Measuring the process of Ambulatory Medical Care. Family Medicine 1987; 19:170-171

7. Froom J: Radical therapy? Scand J. Primary Health Care 1987; 5:1-3

8 Froom J: Teaching communication skills 1987; 14:299-301

9. Froom J, Froom P: Consequences of the National Cholesterol Education Program. J Fam Pract 1991; 30:533-536.

10. Froom J: Blood cholesterol lowering in elderly patients. J Amer Boar Fam Pract. 1991; 4:61-62.

11. Froom J: The long pull. Fam Med 1991;23:17.

12. Froom J: The real enemies: Obesity, inactivity and smoking. J Amer Board of Fam Pract. 1991;4:269-271.

INVITED LECTURES AND PAPERS READ AT MEETINGS—recent

1. "Medical Records and Quality of Care Assessment" to New Jersey Medical Directors or the Group Health Plan of New Jersey, Inc., March 17, 1978.

2. "The Future Family Physician: New Tasks and New Tools" presented at Wright State Medical School, Wright-Patterson Air Force Base, Ohio. March 31, 1978.

3. "Health Related Problems of the Single-Parent Family" North American Primary Care Research Group, Toronto, Canada, April 1978.

4. "Patient Expectations and the Family Physician: A comparison of patient expectations in two populations: Rochester, New York, and Ommoord, THE NETHERLANDS — North American Primary Care Research Group, Toronto, Canada, April 1978.

5. "A Classification of Family and Family Diagnoses for Family Physicians" North American Primary Care Research Group, Toronto, Canada, April 1978.

6. Classification of diseases and recording techniques — Community Health Plan of Suffolk, Inc. December 1978.

7. The Family in Family Medicine Research — Keynote address — Michigan State University - Research Day — February 1978.

8. Selective Screening and Surveillance for Lead Poisoning — Educational Implications — American Assoc. of Medical Colleges — New Orleans — October 1978.

9. The Problem-Oriented Medical Record - Southern Medical Association — Atlanta, Georgia - November 1978.

10. Classification of Diseases — Southern Medical Association — Atlanta, Georgia — November 1978.

11. The Spectrum of Otitis Media in Family Practice — World Organization of National Colleges Academies and Academic Associations of General Practitioners — Family Physicians — Montro, Switzerland — May 1978.

12. Scientific Investigation in Family Medicine — Nassau County Medical Center — October 1978.

13. Introduction to the Family: Family Life Cycle — Southside Hospital — Denver, Colorado - April, 1979.

14. Critique of Research Design — Society of Teachers of Family Medicine –- Denver, Colorado -April 1979.
15. Classification of Family — Department of Family Medicine — University of Colorado — Denver, Colorado — May 1979.
16. Organizing Practice Generated Data for Research and Teaching — Case Western Reserve —Cleveland — December 1979.
17. Medical Records for Correctional Facilities — New York State Correctional Department, Health Services Division — February 1980.
18. Urinary Tract Infections — Department of Family Medicine — University of Colorado — December 1981.
19. Classification Systems in Primary Care — Dept. of Family Medicine — University of Colorado — December 1981.
20. New Directions in Primary Care Classification Systems — Panel Discussion — North American Primary Care Research Group — Columbus Ohio — May 1982.
21. Urinary Tract Infections in Primary Care — Post Graduate Family Medicine Course — Stony Brook, NY — March 1982.
22. Low Back Pain — Afula Hospital — Afula, Israel — November 1982.
23. Family Medicine — A Unique Discipline — Medical Staff Conference — Carmel Hospital — Haifa, Israel — November 1982.
24. Diabetes Mellitus — Afula Hospital — Afula, Israel — December 1982.
25. Screening - Department of Family Medicine — Hadassah Hospital — Jerusalem — March 1983.

26. Primary Care Classifications — Department of Social Medicine — Hebrew University — Jerusalem — March 1983.
27. Primary Care Research — Department of Primary Care — Ben Gurion University of the Negev — Beer Sheva, Israel — March 1983.
28. Screening for disease in a family medicine patient population — International Forum on Family Medicine for the Americas, Spain and Portugal. Panama — August 15, 1984.
29. The Problem-Oriented Medical Record, ICHPPC and Practice Based Data Systems — International Forum on Family Medicine for the Americas, Spain and Portugal. Panama — August 16, 1984.
30. Classification of Diseases — Northwestern General Hospital — Burnie — Tasmania — Australia - February 1985.
31. Otitis Media in General Practice — Launceston — Tasmania — Australia — February 1985.
32. Recent Trends in Diabetes Mericy General Hospital — Latrobe — Tasmania — Australia — February 1985.
33. New Developments in the Treatment of Type 2 Diabetes — Royal Hobart Hospital — Tasmania — Australia — February 1985.
34. Diabetes in Primary Care Patients — Department of Family Medicine — University of Sidney — Australia — March 1985.
35. Otitis Media — College of General Practice — Christ Church — New Zealand. Classification of Disease — University of Auckland — New Zealand — March 1985.
36. Otitis Media — Afula Hospital — Israel — July 1985.
37. Low Back Pain — Hadassah Hospital — Israel — October 1985.

38. International Conference on Otitis Media — Jerusalem — Participated in a panel discussion on the natural history and diagnostic criteria

39. Urinary Tract Infection — Hadassah Hospital — Israel — November 1985.

40. Diabetes Mellitus — Carmel Hospital — Israel — November 1985.

41. Otitis Media — Hadassah Hospital — Israel — November 1985.

42. Risks of Referral — Hadassah Hospital — Israel — December 1985.

43. Primary Care Classifications — Hadassah Hospital — Israel — December 1985.

44. Informatics Meeting on Primary Care — Munich — Germany — Computer Compatible Primary Care Classifications Systems — December 1985.

45. Diabetes Mellitus — Tel Aviv University — Israel — January 1986.

46. Selection Bias — Hatzor Clinic — Israel — January 1986.

47. Treating Asymptomatic Patients — Keynote Address — Annual Research Day — Afula, Israel 1990

48. The Cholesterol Controversy, Hebrew University, Jerusalem, Israel 1990

49. Does Chapter XXI Meet the Needs for Healthcare Information in the 1990's? CPHA Symposium, Chicago 1990.

50. Urinary Tract Infections: A proposal for primary care research. Portuguese Hospital: Rio Di Janiero, Brazil.

51. Research in Family Medicine. Practitioner Involvement in Research Networks. Keynote Address. Connecticut Academy of Family Physicians 1991 Scientific Symposium.

52. NIMH International Research Conference on the Classification, Recognition and Treatment of Mental Disorders in General Medical Settings. Winter-Season Morbidity in a Random Sample of Primary Medical Care Outpatients. Washington D.C. - September 23, 1991.

53. Effect of Patient Characteristics, Disease Severity, and Treatment on the Outcome of Acute Otitis Media. A report from IPCN. North American Primary Care Research Group. Quebec, Canada - May 1991.

54. Heart Disease Prevention Research. Wisconsin Research Network. November 1991.

55. Primary Care Practice-Based Research Network. A National and International Perspective. Keynote address. Wisconsin Research Network - November 1991.

56. Cholesterol Reduction and Other Cardiovascular Disease Prevention Interventions. Grand Rounds, Duke University. Department of Family Medicine - November 1991.

57. Medical School Education. Contrasts Between Japan and the United States. Okayama Medical School. Japan - September 1991.

58. Urinary Tract Infections in Primary care Patients. Hadassah Medical School Jerusalem - February 12, 1992.

59. Detection of Depression in Primary Care Patients. National Association of Family Physicians Annual research Convocation. Tiberias. March 3, 1992.

60. Research Design. Ben-Gurion University of the Negev. March 10, 1992.

61. Detection of Occult Hypothyroidism in Primary Care Populations. Ben-Gurion University of the Negev. March 11, 1992.

62. Acute Otitis media: Findings from a Nine-country Study. Hadassah Medical School. March 23 1992.

63. June 8, 1992: Controversies in the Medical Literature: Keynote address at a conference on teaching technique for family physicians. Tel Aviv, University Israel.

AUDIO

Froom J: Office screening for lead poisoning in children. Highlights from the American Academy of Pediatrics 1977 Annual Meeting, New York City, November 5-10, 1977. AUDIO DIGEST Foundation. Pediatrics 24:1, Side B, January 17, 1978.

SCIENTIFIC EXHIBITS - NATIONAL MEETINGS

1. "The Diagnostic Index--E Book" with Drs. Eugene Farley, Donald F. Treat, and Samuel Henck to the Annual Scientific Assembly of the American Academy of Family Physicians, October 14-17, 1974, Los Angeles, California. First Prize awarded for outstanding exhibit.
2. Lead Screening by Primary Care Physician, American Academy of Pediatrics, New York 1977
   American Public Health Associates, Washington 1977

HOSPITAL MEDICAL STAFF MEMBERSHIP

University Hospital, State University of New York at Stony Brook, N.Y. 1978-Present

AWARDS AND HONORS

1. Scholar in Residence at the Rockefeller Bellagio Study and Conference Center April 1982.
2. Fulbright - Hays Fellowship to teaching Israel October 1982-March 1983.
   Visiting Professor - Technion University Haifa. October 1982-March 1983.

Visiting Professor - University of Tel Aviv. October 1982-March 1983.

3. Visiting Professor - Hebrew University - Jerusalem - May 1985 - January 1986 and Jan-July 1992.
4. Hames Research Award - Society of Teachers of Family Medicine 1987.
5. Certificate of Excellence - Society of Teachers of Family Medicine 1990.
6. Visiting Professor - Okayama Medical School - Japan - September 1991.
7. Life Honorary member in the Israel Association of Family Physicians, June 1992.
8. Fellow of WONCA (World Organization of Family Physicians.)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker
PERKINS COIE
1201 Third Avenue, 40th Floor
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(206) 583-8888

Carla A. Kerr (CK 5194)
HUGHES HUBBARD & REED
One Battery Park Plaza
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(212) 837-6000

Attorneys for Plaintiffs

DECLARATION OF MINNA BARRETT

Minna Barrett declares:

1. I am competent to testify and do so of my own personal knowledge. I submit this declaration in support of plaintiffs' motion to add Governor Mario M. Cuomo as defendant herein.

2. On Sunday, September 18, 1994, I watched a televised panel discussion with Governor Mario M. Cuomo and I recall the following discussion.

3. Governor Cuomo had been discussing the high prison population and violence in the streets. He was asked about his position on the death penalty. He said he was opposed.

In the context of a fuller discussion about issues of the gubernatorial race, a panelist asked the Governor how he felt about the pending lawsuit challenging the Attorney General on hastening death and allowing mentally competent terminally ill people control over their own deaths. Governor Cuomo responded that he was opposed to that right.

4. The panelist further pressed the issue, asking the Governor how he could oppose the right of mentally competent individuals, faced with terminal and horribly painful diseases, to alleviate this suffering by hastening a sure death and how he could possibly equate the death penalty, an act of punishment, with assisted death, an act of mercy.

5. Governor Cuomo responded that the panel had just finished discussing the violence that permeates society, whether it take the form of the violence that children face on the streets or the form of the death penalty. Governor Cuomo explained that allowing terminally ill individuals the right to hasten their own deaths is the equivalent of the State condoning the above mentioned kinds of violence.

6. The panelist then asked again how he could equate murder and violence with mercy and suggested that physician-

assisted death in the case of mentally competent, terminally ill individuals should be viewed as a right. She asked him what his position on abortion was, to which Cuomo firmly replied that abortion was a woman's right which was not up to review.

7. When the panelist again stated that she did not understand how he could equate physician-assisted death with murder, Cuomo told her that she had "no conscience." He then drew his own analogy, declaring that permitting these terminally ill individuals to hasten their own deaths was no different than condoning the murder we see in the streets by "putting guns in the hands of children."

I declare under penalty of perjury that the foregoing is true and correct.

Dated: October 12, 1994
Oceanside, New York

/s/ MINNA S. BARRETT
Minna Barrett

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
October 14, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

Kathryn L. Tucker
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1201 Third Avenue, 40th Floor
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Carla A. Kerr (CK 5194)
Tracy E. Poole (TP 3484)
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(212) 837-6000

Attorneys for Plaintiffs

AMENDED COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

Plaintiffs, for their complaint, allege:

PARTIES

1. George A. Kingsley is a mentally competent, terminally ill adult who resides in New York City.

2. Howard A. Grossman, M.D., is a physician licensed in the State of New York who practices internal medicine, primarily treating patients with AIDS, in New York City. Dr. Grossman sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

3. Samuel C. Klagsbrun, M.D., is a physician licensed in the State of New York who practices psychiatry in New York City and Katonah, New York. Dr. Klagsbrun sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

4. Timothy E. Quill, M.D., is a physician licensed in the State of New York who practices internal medicine in Rochester, New York. Dr. Quill sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

5. G. Oliver Koppell, the Attorney General of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

6. Mario M. Cuomo, the Governor of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

JURISDICTION AND VENUE

7. Plaintiffs bring this action pursuant to 42 U.S.C. § 1983 to redress the deprivation of rights guaranteed by the Fourteenth Amendment to the Constitution of the United States. Plaintiffs seek a declaratory judgment pursuant to the Federal Declaratory Judgments Act, 28 U.S.C. §§ 2201 and 2202, and appropriate injunctive relief. The jurisdiction of this Court is invoked pursuant to 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331 and 1343(a)(3).

8. Venue is properly laid in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

NATURE OF THE ACTION

9. This action seeks a declaratory judgment that the portions of the New York Penal Law sections criminalizing assisted suicide are unconstitutional as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death. This action also seeks appropriate injunctive relief. The sections of the Penal Law provide, in relevant part, that it is a class C felony to intentionally aid another person to commit suicide (N.Y. Penal Law § 125.15(3)), and a class E felony to promote a suicide attempt by intentionally aiding another person to attempt suicide (N.Y. Penal Law § 120.30). By criminalizing physician assistance in these circumstances, the New York Penal Law prevents mentally competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid continued suffering and a lingering, painful death. These portions of sections 125.15(3) and 120.30 deny individuals the liberty and privacy to decide what to do with their own bodies and forces them to endure pain, anguish, and loss of dignity.

FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

10. George A. Kingsley is a 48-year-old publishing industry executive who is suffering from AIDS. Mr. Kingsley has been advised and understands that his illness is a terminal one, that he is in the terminal phase of his disease, and that there is no chance of recovery. Mr. Kingsley is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Kingsley seeks necessary medical assistance in the form of medications prescribed by his physician to be self-administered for the purpose of hastening his death. Without such assistance Mr. Kingsley cannot hasten his death in a certain and humane manner.

11. There are mentally competent, terminally ill adults in the State of New York who desire to have the choice to seek physician assistance to hasten their deaths.

12. In the regular course of Dr. Howard A. Grossman's medical practice, Dr. Grossman treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Grossman encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Grossman's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Grossman from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

13. In the regular course of Dr. Samuel C. Klagsbrun's medical practice, Dr. Klagsbrun treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Klagsbrun encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Klagsbrun's medical practice to assist these patients in their decision to hasten death through the prescription medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Klagsbrun from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

14. In the regular course of Dr. Timothy E. Quill's medical practice, Dr. Quill treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Quill occasionally encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Quill's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law deter Dr. Quill from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

CLAIMS FOR RELIEF

COUNT I

(Violations of Liberty Guaranteed
by Fourteenth Amendment)

15. Plaintiffs repeat and reallege paragraphs 1 through 14 of their Complaint.

16. The Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

17. The Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

18. Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

COUNT II

(Violation of Equal Protection Guaranteed
by Fourteenth Amendment)

19. Plaintiffs repeat and reallege paragraphs 1 through 14 of their Complaint.

20. The Fourteenth Amendment guarantees patient-plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, equal protection under the law of the State of New York. The relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

21. Patient-Plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, patient-plaintiffs and the patients of the physician-plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

(1) A declaration that the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law are invalid

under the Constitution of the United States as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death, and thus violate 42 U.S.C. section 1983.

(2) An order permanently enjoining defendants, and all who act in concert with them, from enforcing the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death.

(3) An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. section 1988.

(4) Such other and further relief as the Court deems just and proper.

DATED: New York, New York
October 12, 1994

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HUGHES HUBBARD & REED

By: CARLA A. KERR
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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed November 4, 1994

TIMOTHY QUILL, *et al.*,

Plaintiffs,

—v.—

G. OLIVER KOPPELL,

Defendant.

Upon plaintiffs' motion to amend their complaint so as to add Mario Cuomo, the Governor of the State of New York, as a party defendant in this matter,

IT IS HEREBY ORDERED, that leave to so amend is granted. Plaintiffs may file and serve such an amended complaint in this matter.

Dated: New York, New York
October 17, 1994

/s/ THOMAS P. GRIESA
THOMAS P. GRIESA
Chief Judge, U.S.D.C.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TG)
Filed October 20, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York,

Defendants.

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Attorneys for Plaintiffs

Order to Show Cause

Upon all the pleadings and proceedings herein and upon the oral motion of plaintiffs in open court on October 19, 1994, it is hereby

ORDERED that plaintiffs may amend their complaint so as to add Robert M. Morgenthau, District Attorney of New York County, as a party defendant in this matter;

IT IS FURTHER ORDERED, that plaintiffs shall serve upon the District Attorney a Summons and Second Amended Complaint, as well as all material filed in this action to date, by hand delivery on October 20, 1994;

IT IS FURTHER ORDERED, that defendant Cuomo as Governor and defendant Morgenthau as District Attorney show cause by serving, by hand, any supplemental papers in opposition on or before November 1, 1994, at 5 o'clock p.m., why a preliminary injunction should not issue pursuant to Rule 65 of the Federal Rules of Civil Procedure enjoining the defendants, their officers, agents, servants, employees, attorneys, successors in office and all others acting under their authority, control, direction, permission or license, and all persons acting in concert and participation with them from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths;

IT IS FURTHER ORDERED, that service of this order to show cause upon defendants on October 20, 1994, by facsimile or by hand, shall be deemed sufficient service as to defendants.

Dated: New York, New York
October 20, 1994

/s/ THOMAS P. GRIESA
Chief Judge Thomas P. Griesa
United States District Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Received October 20, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; and MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

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Attorneys for Plaintiffs

SECOND AMENDED COMPLAINT FOR DECLARATORY JUDGMENT AND INJUNCTIVE RELIEF

Plaintiffs, for their complaint, allege:

PARTIES

1. George A. Kingsley is a mentally competent, terminally ill adult who resides in New York City.

2. Howard A. Grossman, M.D., is a physician licensed in the State of New York who practices internal medicine, primarily treating patients with AIDS, in New York City. Dr. Grossman sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

3. Samuel C. Klagsbrun, M.D., is a physician licensed in the State of New York who practices psychiatry in New York City and Katonah, New York. Dr. Klagsbrun sues on his own behalf and on behalf of his mentally competent, terminally ill patients.

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5. G. Oliver Koppell, the Attorney General of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

6. Mario M. Cuomo, the Governor of the State of New York, has the powers entrusted to him under the Constitution and Executive Law of the State of New York. He is sued in his official capacity.

7. Robert M. Morganthau, District Attorney of New York County, has the powers entrusted to him under the Constitu-

tion and County Law of the State of New York. He is sued in his official capacity.

JURISDICTION AND VENUE

8. Plaintiffs bring this action pursuant to 42 U.S.C. § 1983 to redress the deprivation of rights guaranteed by the Fourteenth Amendment to the Constitution of the United States. Plaintiffs seek a declaratory judgment pursuant to the Federal Declaratory Judgments Act, 28 U.S.C. §§ 2201 and 2202, and appropriate injunctive relief. The jurisdiction of this Court is invoked pursuant to 42 U.S.C. § 1983 and 28 U.S.C. 1331 and 1343(a)(3).

9. Venue is properly laid in the Southern District of New York pursuant to 28 U.S.C. § 1391(b).

NATURE OF THE ACTION

10. This action seeks a declaratory judgment that the portions of the New York Penal Law sections criminalizing assisted suicide are unconstitutional as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death. This action also seeks appropriate injunctive relief. The sections of the Penal Law provide, in relevant part, that it is a class C felony to intentionally aid another person to commit suicide (N.Y. Penal Law § 125.15(3)), and a class E felony to promote a suicide attempt by intentionally aiding another person to attempt suicide (N.Y. Penal Law § 120.30). By criminalizing physician assistance in these circumstances, the New York Penal Law prevents mentally competent, terminally ill adults from exercising the right to choose to hasten inevitable death and thus avoid continued suffering and a lingering, painful death. These portions of sections 125.15(3) and 120.30 deny individuals the liberty and privacy to decide what to do with their own bodies and forces them to endure pain, anguish, and loss of dignity.

FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

11. George A. Kingsley is a 48-year-old publishing industry executive who is suffering from AIDS. Mr. Kingsley has been advised and understands that his illness is a terminal one, that he is in the terminal phase of his disease, and that there is no chance of recovery. Mr. Kingsley is fully aware of the ravages the disease wreaks and the prospect he faces of progressive loss of bodily function and integrity and increasing pain and suffering. Mr. Kingsley seeks necessary medical assistance in the form of medications prescribed by his physician to be self-administered for the purpose of hastening his death. Without such assistance Mr. Kingsley cannot hasten his death in a certain and humane manner.

12. There are mentally competent, terminally ill adults in the State of New York who desire to have the choice to seek physician assistance to hasten their deaths.

13. In the regular course of Dr. Howard A. Grossman's medical practice, Dr. Grossman treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Grossman encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Grossman's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Grossman from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

14. In the regular course of Dr. Samuel C. Klagsbrun's medical practice, Dr. Klagsbrun treats patients who are ter-

minally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Klagsbrun encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Klagsbrun's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law prevent Dr. Klagsbrun from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

15. In the regular course of Dr. Timothy E. Quill's medical practice, Dr. Quill treats patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering. Also in the regular course of his medical practice, Dr. Quill occasionally encounters mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life. Under certain circumstances it would be consistent with the standards of Dr. Quill's medical practice to assist these patients in their decision to hasten death through the prescription of medications. Without such medical assistance these patients cannot hasten their deaths in a certain and humane manner. Sections 125.15(3) and 120.30 of the New York Penal Law deter Dr. Quill from exercising his best professional judgment to prescribe medications to these patients in dosages that would enable them to act to hasten their own deaths.

CLAIMS FOR RELIEF

COUNT I

(Violations of Liberty Guaranteed
by Fourteenth Amendment)

16. Plaintiffs repeat and reallege paragraphs 1 through 15 of their Complaint.

17. The Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering. The right to make this choice is a fundamental right and is entitled to the strongest degree of constitutional protection.

18. The Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

19. Plaintiffs have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

COUNT II

(Violation of Equal Protection Guaranteed
by Fourteenth Amendment)

20. Plaintiffs repeat and reallege paragraphs 1 through 15 of their Complaint.

21. The Fourteenth Amendment guarantees patient-plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, equal protection under the law of the State of New York. The relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

22. Patient-plaintiff George A. Kingsley and the mentally competent, terminally ill patients of physician-plaintiffs Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman, have no adequate remedy at law and face imminent and irreparable loss of their rights. By reason of these violations of their constitutional rights, patient-plaintiffs and the patients of the physician-plaintiffs are entitled to declaratory judgment and injunctive relief against the enforcement of the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that this Court grant the following relief:

(1) A declaration that the relevant portions of Sections 125.15(3) and 120.30 of the New York Penal invalid under the

Constitution of the United States as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death, and thus violate 42 U.S.C. section 1983.

(2) An order permanently enjoining defendants, and all who act in concert with them, from enforcing the relevant portions of sections 125.15(3) and 120.30 of the New York Penal Law as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death.

(3) An award of plaintiffs' costs, expenses, and reasonable attorneys' fees pursuant to 42 U.S.C. section 1988.

(4) Such other and further relief as the Court deems just and proper.

DATED: New York, New York
October 20, 1994

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D., *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL, *et al.*,

Defendants.

DEFENDANTS G. OLIVER KOPPELL AND MARIO M. CUOMO'S ANSWER AND AFFIRMATIVE DEFENSES TO PLAINTIFFS' SECOND AMENDED COMPLAINT

Defendants G. Oliver Koppell and Mario M. Cuomo, by and through counsel, answer plaintiffs' second amended complaint ("complaint"), as follows:

1. Deny knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 1, 2, 3 and 4 of the complaint.

2. Admit the allegations set forth in paragraphs 5, 6, and 7 of the complaint, except that plaintiffs' assertion that defendants are sued in their official capacities states a legal conclusion to which no responsive pleading is required.

3. Paragraph 8 of the complaint states legal conclusions to which no responsive pleading is required. The Court is respectfully referred to the statutes cited therein for their contents.

4. Deny the allegations set forth in paragraph 10 of the complaint, except assert that the first two sentences state legal conclusions to which no responsive pleading is required, and respectfully refer the Court to the statutes cited therein for their contents.

5. Deny knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 11, 12, 13, 14 and 15 of the complaint.

6. In response to paragraph 16 of the complaint, repeat and reallege their answers to paragraphs 1 through 15 of the complaint and incorporate them by reference.

7. Deny the allegations set forth in paragraphs 17, 18 and 19 of the complaint.

8. In response to paragraph 20 of the complaint, repeat and reallege their answers to paragraphs 1 through 19 of the complaint and incorporate them by reference.

9. Deny the allegations set forth in paragraphs 21 and 22 of the complaint.

FIRST AFFIRMATIVE DEFENSE

10. The complaint fails in whole or in part to state a claim upon which relief can be granted.

SECOND AFFIRMATIVE DEFENSE

11. This action is barred in whole or in part by the Eleventh Amendment to the United States Constitution.

12. The Court lacks jurisdiction over the subject matter.

THIRD AFFIRMATIVE DEFENSE

13. This action does not present a case or controversy under Article III of the United States Constitution.

FOURTH AFFIRMATIVE DEFENSE

14. The issue presented is a non-justiciable political question.

WHEREFORE, defendants Koppell and Cuomo respectfully demand that the Court enter judgment dismissing the complaint with prejudice.

Dated: New York, New York
October 28, 1994

G. OLIVER KOPPELL
Attorney General of the
State of New York

By: MICHAEL S. POPKIN
MICHAEL S. POPKIN (MP 3209)
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

94 Civ. 5321 (TG)

TIMOTHY E. QUILL, M.D.;
SAMUEL C. KLAGSBRUN, M.D.;
HOWARD A. GROSSMAN, M.D.; and
GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL,
Attorney General of the State of New York;
MARIO M. CUOMO,
Governor of the State of New York; and
ROBERT M. MORGENTHAU,
District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S MEMORANDUM OF LAW IN OPPOSITION TO MOTION FOR A PRELIMINARY INJUNCTION

ROBERT M. MORGENTHAU
District Attorney
New York County
Defendant Pro Se
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MARK DWYER
JAMES M. McGUIRE
ASSISTANT DISTRICT ATTORNEYS
Of Counsel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S MEMORANDUM OF LAW IN OPPOSITION TO MOTION FOR A PRELIMINARY INJUNCTION

INTRODUCTION

Defendant Robert M. Morgenthau, the District Attorney of New York County, respectfully submits this memorandum of law in opposition to plaintiffs' motion for a preliminary injunction enjoining defendant Morgenthau, the other defendants and all persons acting in concert with the named defendants, "from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths" (Oct. 20, 1994 Order to Show Cause at 2). As argued below in Point I, plaintiffs' motion should be denied because they have failed to demonstrate that issuance of the preliminary injunction is necessary to prevent irreparable injury to their alleged constitutional rights.* Moreover, as argued below in Point II, plaintiffs' motion should also be denied because the injunction they seek is impermissibly vague under Fed. R. Civ. Pro. 65(d) and is otherwise overly broad.

At the outset, however, it is by no means apparent why plaintiffs amended their complaint to add District Attorney Morgenthau, as opposed to any of the other District Attorneys in New York City or State, as a party defendant. After all, defendant Morgenthau can prosecute only those crimes which have a sufficient nexus to New York County. *See* N.Y. Crim. Pro. Law § 20.40 (McKinney's 1992). And plaintiffs do not allege any facts tending to show that the physician-plaintiffs are in any jeopardy of being prosecuted in New York County. In any event, defendant Morgenthau will address this matter in his answer or by appropriate motion.

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* Defendant Morgenthau also submits that the federal constitution does not confer upon plaintiffs the suicide-related rights upon which they rely and that, accordingly, plaintiffs have failed to show a likelihood of success on the merits. However, defendant Morgenthau will not address the merits in this memorandum. Instead, defendant Morgenthau adopts the arguments on the merits made by defendant Koppell and *Amicus Curiae* New York State Catholic Conference.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D., *et al.*,

Plaintiffs,

—against—

G. OLIVER KOPPELL, *et al.*,

Defendants.

AFFIDAVIT OF MICHAEL S. POPKIN ON BEHALF OF DEFENDANT MARIO M. CUOMO IN OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AND IN SUPPORT OF DEFENDANTS' CROSS-MOTION FOR JUDGMENT ON THE PLEADINGS

STATE OF NEW YORK):
: SS.
COUNTY OF NEW YORK):

MICHAEL S. POPKIN, being duly sworn, deposes and says, as follows:

1. I am an Assistant Attorney General employed in the office of G. OLIVER KOPPELL, Attorney General of the State of New York, and I make this affidavit on behalf of Mario M. Cuomo, Governor of New York, in response to the

Court's Order to Show Cause in this matter, dated October 20, 1994. I have been duly authorized to make this affidavit. I make it upon personal knowledge, as well as information and belief, the source of such knowledge, information and belief being my familiarity with the proceedings herein; and conversations with the staff of the Governor's office.

2. By this affidavit, the Governor joins in the Attorney General's opposition to plaintiffs' Motion for a Preliminary Injunction, and in the Attorney General's pending Cross-Motion for Judgment on the Pleadings in this matter. For the reasons which appear below, the Governor will not—except for this affidavit,—submit additional papers on the motions under submission.

3. The Governor is sued in this case "in his official capacity." Plaintiffs' Second Amended Complaint at ¶6. With respect to this, it is the position of the Governor that he is not a necessary party to this suit. The Governor personally has not actually taken or threatened any action in this matter for which he is joined as a defendant. It is therefore inappropriate that he be so joined. As is the case with the Attorney General, the Governor does not possess primary authority to enforce the criminal statutes which are at issue in this case. Rather it is the District Attorneys of the several counties of the State who primarily enforce these laws. Parallelling the argument already before the Court, "[N]othing in the Penal Law, the Executive Law, or any other New York Statute authorizes the [Governor] to supervise or dictate to the District Attorneys of the various counties of the State of New York." Defendant's Memorandum of Law In Opposition to Motion for a Preliminary Injunction and in Support of Cross-Motion for Judgment on the Pleadings, at 3-4. Therefore, with respect to the Governor, this case continues not to present a case or controversy ripe for adjudication under Article III of the United States Constitution. The Governor is no more likely to prosecute the plaintiff-physicians in this case than is the Attorney General.

4. With respect to the enforcement of the criminal laws at issue in this case, the Governor believes that New York's various District Attorneys will continue to exercise vigilence and discretion. There is nothing to suggest that these officials will fail to exercise their responsibilities. The Governor's presence in this suit therefore adds nothing from the law enforcement point of view.

5. Further, where the constitutionality of the challenged statutes is concerned, the Governor believes that the interests of the State have been well represented in the papers already submitted by the Attorney General pursuant to his obligation to defend the constitutionality of state statutes. Therefore, because the Attorney General can adequately represent the State's interest in upholding the validity of its laws, the Governor is similarly not a necessary party to this action. Except as to his presence in this case as a defendant, additional arguments on his part are unnecessary.

6. For these reasons, as already indicated, the Governor will not (besides this affidavit) submit additional papers on the cross-motions under submission. In general, the Governor joins in the Attorney General's motion that the case be dimissed on the pleadings for failure to State a cause of action, and in the Attorney General's opposition to plaintiffs' request for a preliminary injunction. And in particular, as it pertains to himself, the Governor asks that the case be dismissed for failure to meet the requirements of Article III of the United States Constitution.

/s/ MICHAEL S. POPKIN
MICHAEL S. POPKIN
Assistant Attorney General

Sworn to before me this
day of 1st day of November, 1994

/s/ [ILLEGIBLE]
Assistant Attorney General of the
State of New York

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S ANSWER TO PLAINTIFFS' SECOND AMENDED COMPLAINT

94 Civ. 5321 (TPG)

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JAMES M. MCGUIRE
Assistant District Attorneys
Of Counsel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of the County of New York,

Defendants.

DEFENDANT ROBERT M. MORGENTHAU'S ANSWER TO PLAINTIFFS' SECOND AMENDED COMPLAINT

Defendant Robert M. Morgenthau answers plaintiffs' second amended complaint as follows:

1. Denies knowledge or information sufficient to form belief as to the truth of the allegations set forth in paragraphs 1, 2, 3, and 4 of the complaint.

2. Admits the allegations set forth in paragraphs 5, 6, and 7 of the complaint, except that plaintiffs' assertions that defendants are sued in their official capacities states a legal conclusion to which no responsive pleading is required.

3. Paragraphs 8 and 9 of the complaint state legal conclusions to which no responsive pleading is required.

4. Denies the allegations set forth in paragraph 10 of the complaint, except asserts that paragraph 10 states legal conclusions to which no responsive pleading is required, and respectfully refers the Court to the statutes cited therein for their contents.

5. Denies knowledge or information sufficient to form a belief as to the truth of the allegations set forth in paragraphs 11, 12, 13, 14 and 15 of the complaint.

6. In response to paragraph 16 of the complaint, repeats and realleges his answers to paragraphs 1 through 15 of the complaint and incorporates them by reference.

7. Denies the allegations set forth in paragraphs 17, 18 and 19 of the complaint.

8. In response to paragraph 20 of the complaint, repeats and realleges his answers to paragraphs 1 through 19 of the complaint.

9. Denies the allegations set forth in paragraphs 21 and 22 of the complaint.

DEFENSES

10. The complaint fails to state a claim upon which relief can be granted.

11. The action does not present a case or controversy under Article III of the United States Constitution.

WHEREFORE, defendant Robert M. Morgenthau respectfully demands that the Court enter judgment dismissing the complaint with prejudice.

Dated: New York, New York
November 9, 1994

ROBERT M. MORGENTHAU
District Attorney
New York County

By: JAMES M. McGUIRE
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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed 11/28/94

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

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Attorneys for Plaintiffs

SECOND SUPPLEMENTAL DECLARATION OF TIMOTHY E. QUILL, M.D.

Timothy E. Quill, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this second supplemental declaration in further support of plaintiffs' motion for a preliminary injunction.

3. I am currently treating mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths if and when their suffering becomes intolerable.

4. These patients have sought my assurance that I will assist them in hastening their deaths by prescribing drugs, if and when medically and psychiatrically appropriate, for them to self administer at the time and place of their choice.

5. The current penal law deters me from providing such assurance, despite my professional responsibility to those patients.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 23, 1994
Rochester, New York

/s/ TIMOTHY E. QUILL, M.D.
TIMOTHY E. QUILL, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed 11/28/94

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

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Attorneys for Plaintiffs

SECOND SUPPLEMENTAL DECLARATION OF SAMUEL C. KLAGSBRUN, M.D.

Samuel C. Klagsbrun, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this second supplemental declaration in further support of plaintiffs' motion for a preliminary injunction.

3. I am currently treating mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths if and when their suffering becomes intolerable.

4. These patients have sought my assurance that I will assist them in hastening their deaths by prescribing drugs, if and when medically and psychiatrically appropriate, for them to self administer at the time and place of their choice.

5. The current penal law deters me from providing such assurance, despite my professional responsibility to those patients.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 23, 1994
New York, New York

/s/ SAMUEL C. KLAGSBRUN, M.D.
SAMUEL C. KLAGSBRUN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)
Filed 11/28/94

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.; and GEORGE A. KINGSLEY,

Plaintiffs,

—v.—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

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Attorneys for Plaintiffs

SECOND SUPPLEMENTAL DECLARATION
OF HOWARD A. GROSSMAN, M.D.

Howard A. Grossman, M.D. declares:

1. I am a plaintiff in this matter, am competent to testify and do so of my own personal knowledge.

2. I make this second supplemental declaration in further support of plaintiffs' motion for a preliminary injunction.

3. I am currently treating mentally competent, terminally ill patients who understand their condition, diagnosis, and prognosis and wish to avoid prolonged suffering by hastening their deaths if and when their suffering becomes intolerable.

4. These patients have sought my assurance that I will assist them in hastening their deaths by prescribing drugs, if and when medically and psychiatrically appropriate, for them to self administer at the time and place of their choice.

5. The current penal law deters me from providing such assurance, despite my professional responsibility to those patients.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: November 23, 1994
New York, New York

/s/ HOWARD A. GROSSMAN, M.D.
HOWARD A. GROSSMAN, M.D.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 CIV. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants.

OPINION

APPEARANCES

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Amicus Curiae

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Amicus Curiae

GRIESA, *Chief Judge*

New York law makes it a crime to aid a person in committing suicide, or in attempting to commit suicide. Plaintiffs urge that these provisions violate the United States Constitution, to the extent that they apply to situations where a physician aids the commission of suicide by a mentally competent, terminally ill adult wishing to avoid continued severe suffering, by prescribing a death-producing drug which the patient takes. Plaintiffs claim that a person has a constitutional right to terminate his life under these circumstances, and that a physician has a corresponding constitutional right not to be prosecuted for aiding a patient in the exercise of the patient's right.

Plaintiffs move for a preliminary injunction against the enforcement of the relevant statutes, §§ 125.15(3) and 120.30 of the New York Penal Law, to the extent they apply to physicians who give the kind of assistance described above. Defendants oppose plaintiffs' motion and cross-move for judgment on the pleadings dismissing the action.

Plaintiffs' motion for preliminary injunction is denied. Defendants' cross-motion to dismiss the action is granted. The motion to dismiss will be treated as one for summary judgment since the court has considered matters outside the pleadings—*i.e.*, declarations filed on the motion for preliminary injunction. There is no dispute on the essential facts and the issues presented are ones of law.

The Parties

The action was commenced on July 20, 1994. The original complaint named three physician plaintiffs, Timothy E. Quill, Samuel C. Klagsbrun, and Howard A. Grossman. There were also three patient plaintiffs who asserted that they were terminally ill and wished to have the assistance of physicians in committing suicide. All three of the patient plaintiffs have now died, leaving only the three physician plaintiffs.

The original complaint named only the Attorney General of the State of New York as a defendant. However, it was argued that the Attorney General was not the proper defendant because he was not responsible for prosecutions under the criminal laws of the State. The complaint has now been amended to add as defendants Governor Mario M. Cuomo and New York County District Attorney Robert M. Morgenthau. There is no longer any question about the fact that there are sufficient defendants present to allow the issues in the case to be litigated.

Amicus curiae briefs in opposition to plaintiffs' position have been filed by the New York State Catholic Conference and the Legal Center for the Defense of Life.

The Relevant Record

The Original Complaint

The original complaint of July 20, 1994 contained, among other things, allegations that the three patient plaintiffs were mentally competent adults; that they were in the terminal stages of fatal illnesses; that they faced progressive loss of bodily function and integrity as well as increasing suffering; and that they desired medical assistance in the form of medications prescribed by physicians to be self-administered for the purpose of hastening death.

As to the three physician plaintiffs, the complaint alleged that, in the regular course of their medical practice, they

treated terminally ill patients who requested assistance in the voluntary self-termination of life; that under certain circumstances it would be consistent with the standards of these physicians to prescribe medications to such patients which would cause death, since without such medical assistance these patients could not hasten their deaths in a certain and humane manner.

The original complaint alleged that the patient plaintiffs have a constitutional right under these circumstances to terminate their lives with this type of medical assistance; and that since the New York Penal Law makes it a crime to render such assistance, these provisions violate the constitutional rights of both the patient plaintiffs and the physician plaintiffs, specifically rights under the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

Amendments to the Complaint

An amended complaint was filed on October 14, 1994. By this time, two of the three patient plaintiffs had died. The allegations about the remaining patient plaintiff were carried over into the amended complaint, as were the claims of the physician plaintiffs.

The second amended complaint was filed October 20, 1994. It was essentially the same as the previous complaint except for naming New York County District Attorney Robert M. Morgenthau as a defendant.

Subsequently, the third patient plaintiff died, thus leaving the three physicians as the only plaintiffs.

An answer was filed in August 1994 to the original complaint denying that plaintiffs have any valid claim. No amended answers were filed responding to the amended complaints, but the court deems the original answer to be a sufficient denial of plaintiffs' claims.

Declarations Filed on Motion For Preliminary Injunction

The motion for preliminary injunction was filed on September 16, 1994. In support of the motion, each of the three patient plaintiffs submitted declarations which confirmed the allegations in the complaint and added details about their diseased conditions and suffering.

The three physician plaintiffs have submitted declarations affirming their belief that proper and humane medical practice should include the ability to prescribe medication which will enable a patient to commit suicide under the circumstances described in this case.

A declaration by Quill also describes the following incident. In 1990 he treated a terminally ill patient, who feared a lingering death and who apprised Quill that she would act on her own to hasten death if he refused to assist her to do so. Quill made barbiturates available to the patient, which she could use to induce sleep, but which she could also take to end her life by an overdose at the point she desired to do so. She agreed to meet with Quill prior to taking any overdose. The patient reached the point where she desired to end her life. She met with Quill "to insure that all alternatives had been explored," after which she took the overdose and died. Quill was not present at the time of death. Subsequently, Quill wrote an article in the New England Journal of Medicine describing these events. This led to what Quill describes as a "very public criminal investigation" in New York State, and presentation to a grand jury. Quill testified before the grand jury, as did other witnesses. The grand jury did not indict.

The other two physician plaintiffs, Klagsbrun and Grossman, describe in their declarations specific incidents when terminally ill patients wished assistance in hastening death. Each doctor asserts that he refrained from rendering such assistance because of possible prosecution under the New York statutes.

The Statutes

Section 125.15(3) of the New York Penal Law provides in relevant part:

> A person is guilty of manslaughter in the second degree when:
>
> . . .
>
> 3. He intentionally . . . aids another person to commit suicide.

Section 120.30 provides:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.

Violation of either statute is a felony.

Plaintiffs are not seeking to strike down these statutes in their entirety. Plaintiffs claim that the statutes are unconstitutional only insofar as they apply to the type of physician assisted suicide at issue in this case. Both plaintiffs and defendants agree that, if a physician renders the type of assistance described here, he will violate § 125.15(3) where actual death by suicide occurs, and § 120.30 where the patient attempts to commit suicide and fails.

DISCUSSION

Justiciability

Defendants assert that there is no justiciable case or controversy as required by Article III of the Constitution. According to defendants, plaintiffs show nothing more than a speculative possibility of prosecution, rather than any actual threat of prosecution.

The court does not agree with these assertions. The relevant law is well set forth in *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289 (1979). There the Supreme Court dealt

with a constitutional challenge to certain Arizona agricultural labor regulations. The case was brought by a union and parties connected with the union. The Court held that certain of the plaintiffs' claims were justiciable and certain were not. The Court stated that when contesting the constitutionality of a criminal statute it is not necessary that the plaintiff first expose himself to actual prosecution. When the plaintiff has alleged an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution, a sufficient controversy is presented. On the other hand, where there are no fears of prosecution except those which are imaginary or speculative, there is no basis for federal court action. "Abstract questions" are not justicible. *Id.* at 297-99.

In *Babbitt* the Court upheld federal jurisdiction over claims where (1) the plaintiffs asserted both the intention and the constitutional right to engage in conduct which would violate the regulations, and (2) the state had not disavowed the intention of imposing criminal penalties. Thus the plaintiffs were "not without some reason in fearing prosecution," and the positions of the parties were "sufficiently adverse" to present a proper case. *Id.* at 302-3.

As to the claims in *Babbitt* held not to be justiciable, the Court found that it was uncertain whether the particular activities involved would actually give rise to a problem under the regulations. The factual pattern which might develop was unclear. *Id.* at 303-4.

Another instructive case is *Doe v. Bolton*, 410 U.S. 179 (1973). This was a companion abortion case to *Roe v. Wade*, 410 U.S. 113 (1973). In *Doe*, the plaintiffs challenged the Georgia anti-abortion statute. The Court held, among other things, that the claim of the physician plaintiffs presented a justiciable controversy. This was true despite the fact that none of them had been prosecuted or threatened with prosecution. The Court pointed out, 410 U.S. at 188:

> The physician is the one against whom these criminal statutes directly operate in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief.

On the basis of these authorities, the court holds that the instant case presents a justiciable controversy under Article III of the Constitution. The three physician plaintiffs seek to carry on activities which they contend are within their constitutional rights and which would violate the New York Penal Law. This is not a case about some activity in which a plaintiff might possibly engage and which might create a hypothetical issue of criminal liability. The physician plaintiffs credibly assert that they have had cases and continue to have cases in which their services are urgently sought to assist in the commission of suicide in the way described in this case. As to whether there is a threat of prosecution for so assisting, there has been the grand jury proceeding about plaintiff Quill. Although no indictment was returned, the State has by no means disavowed the intention of acting against physicians in future cases. Indeed, the State has in the present action vigorously defended its right to apply the statutes to such conduct. Thus, there is a credible threat of prosecution giving rise to sufficiently adverse positions so that a justiciable controversy exists. What is presented here is no mere abstract question.

This is particularly true since the issue of physician assisted suicide is being pressed by segments of the medical community and has sparked sharp public debate. It is most unlikely that the conduct at issue in this case would be ignored by the law enforcement authorities.

It is appropriate to note that the primary right claimed is that of the patient—*i.e.*, the right to decide to terminate one's life and to do so by suicide. However, if such a constitutional right resides in the patient, then there would be a corresponding constitutional right of the physician not to be prosecuted for assisting in the exercise of the patient's con-

stitutional right. The physician plaintiffs in the present case have standing to raise the whole range of issues—both as to the patient's asserted right to terminate his life and the physician's right to be free from prosecution for rendering assistance. *See Doe*, 410 U.S. at 188.

The Due Process Issue

The Fourteenth Amendment provides that no state may "deprive any person of life, liberty, or property, without due process of law." It is now established that there are certain subjects which are so fundamental to personal liberty that governmental invasion is either entirely prohibited or sharply limited. One recent articulation of this concept by the Supreme Court, which is strongly relied upon by plaintiffs, is contained in the plurality opinion in *Planned Parenthood v. Casey*, 112 S.Ct. 2791, 2807 (1992).

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family-relationships, child rearing, and education. . . . These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Casey confirmed the holding in *Roe v. Wade* that the Fourteenth Amendment protects a woman's decision to abort a pregnancy in the pre-viability stage.

Plaintiffs also rely on the Supreme Court decision in *Cruzan v. Director Missouri Dep't of Health*, 497 U.S. 261 (1990). In that case a woman suffered an accident, after which she could only be kept alive by artificial feeding and hydration. She lost her cognitive faculties, and apparently had no possibility of recovery. Her parents desired to have the life-sustaining apparatus withdrawn. The Supreme Court of Missouri held that it was necessary, before such a step could be taken, to show by clear and convincing evidence that the injured woman would have desired withdrawal of the medical devices, and further held that such evidence was lacking.

Although the United States Supreme Court, in reviewing the case, did not provide a single convenient statement of the question before it, a fair summary of the issues would appear to be whether the injured woman had a constitutional right requiring the hospital to withdraw life-sustaining treatment; whether this right could be exercised on behalf of the woman by her parents; and whether the exercise of this right was unduly hampered by the evidence rule imposed by the state court. In approaching these questions the Supreme Court stated:

> The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions.

Id. at 278. The Court went on to discuss the specific issue of whether this general right to refuse treatment would apply where such refusal might lead to death.

> Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent

person a constitutionally protected right to refuse life-saving hydration and nutrition.

Id. at 279. Thus, the Court stopped short of actually deciding that there is a constitutional right to terminate medical treatment necessary to sustain life, although the Court *assumed* the existence of such a right for the purpose of going on to the other issues in the case. As to these, the Court held that the state had the power to require evidence of the patient's wishes rather than allowing the decision solely at the behest of family members, and that the state could properly require proof of the patient's wishes by clear and convincing evidence.

Plaintiffs in the present case argue that the reasoning and holdings of the Supreme Court in *Roe* and *Casey* are broad enough to establish that there is a fundamental right on the part of a terminally ill patient to decide to end his life, and to do so with the type of assistance described in this case. Plaintiffs also interpret the *Cruzan* decision as being tantamount to a holding that a terminally ill person has a constitutional right to require the withdrawal of life-sustaining treatment. Plaintiffs argue that it follows inevitably that there is a constitutional right of physician assisted suicide under the circumstances and in the manner at issue here.

Plaintiffs' reading of these cases is too broad. The Supreme Court has been careful to explain that the abortion cases, and other related decisions on procreation and child rearing, are not intended to lead automatically to the recognition of other fundamental rights on different subjects. *See, e.g., Bowers v. Hardwick*, 478 U.S. 186, 191 (1986); *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68, n.15 (1973). With regard to *Cruzan*, as already described, the Court did not actually make the holding upon which plaintiffs seek to rely. In any event, it would appear clear that suicide has a sufficiently different legal significance from requesting withdrawal of treatment so that a fundamental right to suicide cannot be implied from *Cruzan*.

The Supreme Court has described the considerations which are appropriate before there can be a declaration that rights

"not readily identifiable in the Constitution's text" are deserving of constitutional protection. *See Bowers*, 478 U.S. at 191. Such rights must be implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed. The Supreme Court has also characterized such rights as those liberties that are deeply rooted in the nation's history and traditions. *Id.* at 191-92. *See also Moore v. East Cleveland*, 431 U.S. 494, 503 (1977).

The trouble is that plaintiffs make no attempt to argue that physician assisted suicide, even in the case of terminally ill patients, has any historic recognition as a legal right. The history of the treatment of suicide by the law has been dealt with in a number of recent studies. *See, e.g.*, Thomas J. Marzen et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 17-100 (1986); Note, *Physician-Assisted Suicide and New York Law*, 57 Alb. L. Rev. 819, 824-32 (1994); The New York State Task Force on Life and The Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 54-56 (1994). Justice Scalia's concurring opinion in *Cruzan*, 497 U.S. at 294-95, also contains a useful historical summary.

Suicide was a crime under English common law, even if the motive was to avoid suffering and illness. Obviously, no punishment could be inflicted upon the deceased, but sanctions were imposed by way of forfeiture of property and ignominious burial. The American colonies apparently adopted this common law rule, but it has been gradually abandoned so that no state in this country now criminalizes suicide or attempted suicide. However, as Justice Scalia states, this change in the law resulted from a desire "to spare the innocent family and not to legitimatize the act." *Cruzan*, 497 U.S. at 294.

As to assisting suicide, the majority of states in this country have long imposed criminal penalties on one who aids another in committing suicide. *See Cruzan*, 497 U.S. at 280 (majority opinion). The Model Penal Code, adopted by the American Law Institute, provides that it is a crime to assist a suicide. *Model Penal Code* § 210.5(2) and comment at 100 (American Law Institute 1980). The comment states:

> Self destruction is surely not conduct to be encouraged or taken lightly. The fact that penal sanctions wil prove ineffective to deter the suicide itself does not mean that the criminal law is equally powerless to influence the behavior of those who would aid or induce another to take his own life. Moreover, in principle it would seem that the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request of the suicide victim.

Plaintiffs are, of course, suggesting a limited form of physician assisted suicide. But plaintiffs have pointed to nothing in the historical record to indicate that even this form of assisted suicide has been given any kind of sanction in our legal history which would help establish it as a constitutionalright.

For these reasons, the court holds that the type of physician assisted suicide at issue in this case does not involve a fundamental liberty interest protected by the Due ProcessClause of the Fourteenth Amendment.

The Equal Protection Issue

Plaintiffs contend that even if there is no fundamental right to engage in assisting a patient's suicide under the Due Process Clause, they should prevail under the Equal Protection Clause. Their argument proceeds thus. It is established under New York law that a competent person may refuse medical treatment, even if the withdrawal of such treatment wil result in death. *See, e.g., Rivers v. Katz*, 67 N.Y.2d 485, 493, 504 N.Y.S.2d 74, 78, 495 N.E.2d 337 (1986); *In Re Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64 (1981); *Schloendorff v. Soc'y of N.Y. Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

Plaintiffs further argue that such refusal of treatment is essentially the same thing as committing suicide with the advice of a physician. Plaintiffs urge that for the State to sanction one course of conduct and criminalize the other involves discrimination which violates the Equal Protection Clause of the Fourteenth Amendment.

The issue is whether the distinction drawn by New York law has a reasonable and rational basis. *Dandridge v. Williams*, 397 U.S. 471, 485, 487 (1969). To certain ways of thinking, there may appear to be little difference between refusing treatment in the case of a terminally ill person and taking a dose of medication which leads to death. But to another way of thinking there is a very great difference. In any event, it is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device. The State has obvious legitimate interests in preserving life, and in protecting vulnerable persons. The State has the further right to determine how these crucial interests are to be treated when the issue is posed as to whether a physician can assist a patient in committing suicide. Clearly in the present public debate there are sincere and conscientious advocates for and against the concept of physician assisted suicide. Under the United States Constitution and the federal system it establishes, the resolution of this issue is left to the normal democratic processes within the State.

For these reasons the court holds that plaintiffs have not shown a violation of the Equal Protection Clause of the Fourteenth Amendment.

It should be noted that one federal district court has taken a view contrary to what is expressed in this opinion as to both the due process and the equal protection issues. *Compassion in Dying v. Washington*, 850 F. Supp. 1455 (W.D. Wash. 1994). That ruling is on appeal to the Ninth Circuit.

CONCLUSION

Plaintiffs' motion for a preliminary injunction is denied. Defendants' motion to dismiss, treated as a motion for summary judgment, is granted, and the action is dismissed.

SO ORDERED.

Dated: New York, New York
December 15, 1994

/s/ THOMAS P. GRIESA
Thomas P. Griesa
U.S.D.J.

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

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94 CIVIL 5321(TPG)
Filed December 21, 1994

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs,

—against—

G. OLIVER KOPPELL, Attorney General of the State of New York; MARIO M. CUOMO, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants.

JUDGMENT

Plaintiffs having moved for a preliminary injunction against the enforcement of the relevant statutes, Sections 125.15(3) and 120.30 of the New York Penal Law, to the extent they apply to physicians who give the kind of assistance described the Court's Opinion, defendants having opposed the motion and having cross-moved for judgment on the pleadings dismissing the action, and the said motions having come before the Honorable THOMAS P. GRIESA, U.S.D.J., and the Court on its own initiative having treated defendants' motion to dis-

miss as a motion for summary judgment, and the Court thereafter on December 16, 1994, having rendered its opinion (#74086); denying plaintiffs' motion for a preliminary injunction, and granting defendants' motion to dismiss, treated as a motion for summary judgment, and dismissing the action, it is,

ORDERED, ADJUDGED AND DECREED: That plaintiffs' motion for a preliminary injunction be and it is hereby denied, and it is further,

ORDERED, that defendants' motion to dismiss, treated as a motion for summary judgment, be and it is hereby granted, and it is further,

ORDERED, that the action be and it is hereby dismissed for the reasons stated in the Court's Opinion, dated December 16, 1994.

DATED: NEW YORK, NEW YORK
December 21, 1994

/s/ JAMES M. PARKISON
Clerk

By: RONALD ? CHURCH
Deputy Clerk

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

No. 94 Civ. 5321 (TPG)

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; HOWARD A. GROSSMAN, M.D.,

Plaintiffs,

—v.—

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGANTHAU, District Attorney of New York County,

Defendants.

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NOTICE OF APPEAL

Notice is hereby given that TIMOTHY E. QUILL, SAMUEL C. KLAGSBRUN, and HOWARD A. GROSSMAN, plaintiffs in the above-named case, hereby appeal to the United States Court of Appeals for the Second Circuit from the Judgment entered in this action on December 21, 1994.

DATED: New York, New York
January 3, 1995

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UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 60—August Term, 1995

(Argued: September 1, 1995 Decided: April 2, 1996)

Docket No. 95-7028

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Plaintiffs-Appellants,

—v.—

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; ROBERT M. MORGENTHAU, District Attorney of New York County,

Defendants-Appellees.

Before:

MINER and CALABRESI, *Circuit Judges*,
and POLLACK, *Senior District Judge*.*

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* The Honorable Milton Pollack of the United States District Court for the Southern District of New York, sitting by designation.

Appeal from summary judgment for defendants entered in the United States District Court for the Southern District of New York (Griesa, Ch. J.) in action to declare unconstitutional two New York statutes penalizing assistance in suicide to extent that the statutes prohibit physicians from acceding to requests of terminally-ill, mentally competent patients for drugs to hasten death.

Affirmed in part and reversed in part.

Judge Calabresi concurs in a separate opinion.

KATHRYN L. TUCKER, Perkins Coie, Seattle, WA, and CARLA A. KERR, Hughes Hubbard & Reed, New York, NY (David J. Burman, Thomas L. Boeder, Kari Anne Smith, Perkins Coie, Seattle, WA, Leigh A. Roveda, Hughes Hubbard & Reed, New York, NY, of counsel), *for Plaintiffs-Appellants*.

MICHAEL POPKIN, Assistant Attorney General, New York, NY (Dennis C. Vacco, Attorney General of the State of New York, Victoria Graffeo, Solicitor General, Kathie Ann Whipple, Acting Bureau Chief, Litigation Bureau, Susan L. Watson, Assistant Attorney General, of counsel), *for Defendants-Appellees*.

MARC FRAZIER SCHOLL, Assistant District Attorney, New York, NY (Robert M. Morgenthau, District Attorney of New York County, Marc Dwyer, Assistant

District Attorney, of counsel), *for Defendant-Appellee Robert M. Morgenthau*.

(Michael L. Costello, New York State Catholic Conference, Albany, NY, Mark E. Chopko, Michael F. Moses, United States Catholic Conference, Washington, DC, of counsel), for United States Catholic Conference and New York State Catholic Conference as *amici curiae*.

(Michael Tierney, New York, NY, of counsel), for New York State Right to Life Committee, Inc. as *amicus curiae*.

(James Bopp, Jr., Richard E. Coleson, Bopp, Coleson & Bostrom, Terre Haute, IN, of counsel), for The National Right To Life Committee, Inc. as *amicus curiae*.

(Paul Benjamin Linton, Clarke D. Forsythe, Americans United for Life, Chicago, IL, of counsel), for Members of the New York State Legislature as *amici curiae*.

(Cameron Clark, Claudia L. Hammerman, New York, NY, of counsel), for Lambda Legal Defense and Education Fund, Inc., National Association of People with AIDS, Unitarian Universalist Association, Americans for Death with Dignity, Death with Dignity Education Center, Gray Panthers Project Fund, Hemlock Society, and Minna Barrett as *amici curiae*.

MINER, *Circuit Judge*.

Plaintiffs-appellants Timothy E. Quill, Samuel C. Klagsbrun and Howard A. Grossman appeal from a summary judgment entered in the United States District Court for the Southern District of New York (Griesa, Ch. J.) dismissing their 42 U.S.C. § 1983 action against defendants-appellees. The action was brought by plaintiffs-appellants, all of whom are physicians, to declare unconstitutional in part two New York statutes penalizing assistance in suicide. The physicians contend that each statute is invalid to the extent that it prohibits them from acceding to the requests of terminally-ill, mentally competent patients for help in hastening death. In granting summary judgment in favor of defendants-appellees, the district court considered and rejected challenges to the statutes predicated upon the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the United States Constitution. *Quill v. Koppell*, 870 F. Supp. 78 (S.D.N.Y. 1994). We reverse in part, holding that physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness.

BACKGROUND

The action giving rise to this appeal was commenced by a complaint filed on July 20, 1994. The plaintiffs named in that complaint were the three physicians who are the appellants here and three individuals then in the final stages of terminal illness: Jane Doe (who chose to conceal her actual identity), George A. Kingsley and William A. Barth. The sole defendant named in that complaint was G. Oliver Koppell, then the Attorney

General of the State of New York. He has been succeeded as Attorney General by Dennis C. Vacco, who has been substituted for him as an appellee on this appeal. According to the complaint, Jane Doe was a 76-year-old retired physical education instructor who was dying of thyroid cancer; Mr. Kingsley was a 48-year-old publishing executive suffering from AIDS; and Mr. Barth was a 28-year-old former fashion editor under treatment for AIDS. Each of these plaintiffs alleged that she or he had been advised and understood that she or he was in the terminal stage of a terminal illness and that there was no chance of recovery. Each sought to hasten death "in a certain and humane manner" and for that purpose sought "necessary medical assistance in the form of medications prescribed by [her or his] physician to be self-administered."

The physician plaintiffs alleged that they encountered, in the course of their medical practices, "mentally competent, terminally ill patients who request assistance in the voluntary self-termination of life." Many of these patients apparently "experience chronic, intractable pain and/or intolerable suffering" and seek to hasten their deaths for those reasons. Mr. Barth was one of the patients who sought the assistance of Dr. Grossman. Each of the physician plaintiffs has alleged that "[u]nder certain circumstances it would be consistent with the standards of [his] medical practice" to assist in hastening death by prescribing drugs for patients to self-administer for that purpose. The physicians alleged that they were unable to exercise their best professional judgment to prescribe the requested drugs, and the other plaintiffs alleged that they were unable to receive the requested drugs, because of the prohibitions contained in sections

125.15(3) and 120.30 of the New York Penal Law, all plaintiffs being residents of New York.

Section 125.15 of the New York Penal Law provides in pertinent part:

> A person is guilty of manslaughter in the second degree when:
>
> . . . .
>
> 3. He intentionally . . . aids another person to commit suicide.

A violation of this provision is classified as a class C felony. *Id.*

Section 120.30 of the New York Penal Law provides:

> A person is guilty of promoting a suicide attempt when he intentionally . . . aids another person to attempt suicide.

A violation of this provision is classified as a class E felony. *Id.*

Count I of the complaint included an allegation that "[t]he Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives." It also included an allegation that

> [t]he Fourteenth Amendment guarantees the liberty of physicians to practice medicine consistent with their best professional judgment, including using their skills and powers to facilitate the exercise of the decision of competent, terminally ill adults to hasten inevitable death by prescribing suitable medications for the patient to self-administer for that purpose.

Count II of the complaint included an allegation that

> [t]he relevant portions of . . . the New York Penal Law deny the patient-plaintiffs and the patients of the physician-plaintiffs the equal protection of the law by denying them the right to choose to hasten inevitable death, while terminally ill persons whose treatment includes life support are able to exercise this choice with necessary medical assistance by directing termination of such treatment.

In their prayer for relief the plaintiffs requested judgment declaring the New York statutes complained of constitutionally invalid and therefore in violation of 42 U.S.C. § 1983 "as applied to physicians who assist mentally competent, terminally ill adults who choose to hasten inevitable death." Plaintiffs also sought an order permanently enjoining defendants from enforcing the statutes and an award of attorney's fees.

By order to show cause filed on September 16, 1994, the plaintiffs moved for a preliminary injunction to enjoin then-Attorney General Koppell "and all persons acting in concert and participation with him from enforcing New York Penal Law sections 125.15(3) and 120.30 against physicians who prescribe medications which mentally competent, terminally ill patients may use to hasten their impending deaths." A declaration by each of the plaintiffs was submitted in support of the application, although Jane Doe had died prior to the filing of the order to show cause. Plaintiffs Kingsley and Barth were then in the advanced stages of AIDS and therefore sought an immediate determination by the district court.

In her declaration, Jane Doe stated:

> I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is

collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ablity to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my plural [sic] cavity and it is painful to yawn or cough. . . . In early July 1994 I had the [feeding] tube implanted and have suffered serious problems as a result. . . . I take a variety of medications to manage the pain. . . . It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state. . . . At this time, it is clear to me, based on the advice of my doctors, that I am in the termnal phase of this disease. . . . At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intenion of hastening my death through the consumption of drugs prescribed for that purpose.

Mr. Kingsley subscribed to a declaration that included the following:

> At this time I have almost no immune system function. . . . My first major illness associated with AIDS was cryptosporidiosis, a parasitic infection which caused me severe fevers and diarrhea and associated pain, suffering and exhaustion. . . . I also suffer from cytomegalovirus ("CMV") retinitis, an AIDS-related virus which attacks the retina and causes blindness. To date I have become almost completely blind in my left eye. I am at risk of losing my sight altogether from this condition. . . . I also suffer from toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain. . . . I . . . take daily infusions of cytovene for the . . . retinitis condition. This medication, administered for an hour through a Hickman tube which is connected to an artery in my chest, prevents me from ever taking showers and makes simple routine functions burdensome. In addition, I inject my leg daily with neupogen to combat the deficient white cell count in my blood. The daily injection of this medication is extremely painful. . . . At this point it is clear to me, based on the advice of my doctors, that I am in the terminal phase of [AIDS]. . . . It is my desire that my physician prescribe suitable drugs for me to consume for the purpose of hastening my death when and if my suffering becomes intolerable.

In his declaration, Mr. Barth stated:

> In May 1992, I developed a Kaposi's sarcoma skin lesion. This was my first major illness associated with AIDS. I underwent radiation and chemotherapy to treat this cancer. . . . In September 1993, I was diagnosed with cytomegalovirus ("CMV") in my stomach and colon which caused severe diarrhea, fevers and wasting. . . . In February 1994, I was diagnosed with microsporidiosis, a parasitic infection for which there is effectively no treatment. . . . At approximately the same time, I contracted AIDS-related pneumonia. The pneumonia's infusion therapy treatment was so extremely toxic that I vomited with each infusion. . . . In March 1994, I was diagnosed with cryptosporidiosis, a parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting.

> I have begun to lose bowel control . . . . For each of these conditions I have undergone a variety of medical treatments, each of which has had significant adverse side effects. . . . While I have tolerated some [nightly intravenous] feedings, I am unwilling to accept this for an extended period of time. . . . I understand that there are no cures. . . . I can no longer endure the pain and suffering . . . and I want to have drugs available for the purpose of hastening my death.

A cross-motion for judgment on the pleadings was filed by Attorney General Koppell on October 11, 1994. Thereafter, on October 14, 1994, an amended complaint was filed by the three physicians and Mr. Kingsley naming as defendants Attorney General Koppell and New York State Governor Mario M. Cuomo. The counts of the complaint were the same as set forth in the original complaint, alleging violations of liberty interests guaranteed by the Fourteenth Amendment in Count I and violation of equal protection rights guaranteed by the Fourteenth Amendment in Count II. The prayer for relief remained the same as in the original complaint. Supplemental declarations in support of the plaintiff's motion for preliminary injunction also were filed on October 14, 1994. In their supplemental declarations, Doctors Klagsbrun and Grossman reiterated their desire "to prescribe drugs, if and when medically and psychiatrically appropriate, for such patients to self-administer at the time and place of their choice for the purpose of hastening their impending deaths."

In his supplemental declaration, Dr. Quill declared:

> The removal of a life support system that directly results in the patient's death requires the direct

> involvement by the doctor, as well as other medical personnel. When such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live. Their doctors do a careful clinical assessment, including a full exploration of the patient's prognosis, mental competence to make such decisions, and the treatment alternatives to stopping treatment. It is legally and ethically permitted for physicians to actively assist patients to die who are dependent on life-sustaining treatments. . . . Unfortunately, some dying patients who are in agony that can no longer be relieved, yet are not dependent on life-sustaining treatment, have no such options under current legal restrictions. It seems unfair, discriminatory, and inhumane to deprive some dying patients of such vital choices because of arbitrary elements of their condition which determine whether they are on life-sustaining treatment that can be stopped.

Along with the supplemental declarations filed on October 14th, an original declaration in support of the motion was filed by Dr. Jack Froom, a physician and Professor of Family Medicine with substantial experience in detecting depression in primary care patients. He declared:

> Physicians can determine whether a patient's request to hasten death is rational and competent or motivated by depression or other mental illness or instability. Physicians currently make these determinations as to patient capacity to make end-of-life decisions with respect to orders not to resuscitate and refusal of life-sustaining treatment. . . . Terminally ill persons who seek to hasten death by con-

suming drugs need medical counseling regarding the type of drugs and the amount and manner in which they should be taken, as well as a prescription, which only a licensed medical doctor can provide. . . . Knowing what drug, in what amount, will hasten death for a particular patient, in light of the patient's medical condition and medication regimen, is a complex medical task. . . . It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice. . . . Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.

A second amended complaint was filed on October 20, 1994. The parties, allegations and prayer for relief were the same as those contained in the first amended complaint, except that Robert M. Morgenthau, District Attorney of New York County, was added as a defendant in his official capacity. Both Dr. Grossman and Dr. Klagsbrun practice medicine in New York City, and Mr. Morgenthau is responsible for the prosecution of crimes occurring in New York County. The physician plaintiffs each filed second supplemental declarations on November 28, 1994, in support of the motion for a preliminary injunction. Each stated that he was currently treating mentally competent, terminally-ill patients who desired to hasten their deaths by self-administering drugs to be provided by the physicians "if and when medically and psychiatrically appropriate." These patients, according to the physicians, understood "their condition, diagnosis, and prognosis and wish[ed] to avoid prolonged suffering by hastening their deaths if and when their

suffering [became] intolerable." None of the three terminally-ill plaintiffs named in the original complaint survived to the date of the district court's decision.

The opinion of the district court was filed on December 16, 1994. The district court denied the motion for a preliminary injunction and granted the defendants' cross motion to dismiss the action, treating the cross motion as one for summary judgment "since the court has considered matters outside the pleadings—*i.e.*, declarations filed on the motion for preliminary injunction." *Quill*, 870 F. Supp. at 79. After finding that the action presented a justiciable case or controversy, the district court first addressed the due process issue. The court determined that physician assisted suicide could not be classified as a fundamental right within the meaning of the Constitution:

> The Supreme Court has described the considerations which are appropriate before there can be a declaration that rights "not readily identifiable in the Constitution's text" are deserving of constitutional protection. Such rights must be implicit in the concept of ordered liberty so that neither liberty nor justice would exist if they were sacrificed. The Supreme Court has also characterized such rights as those liberties that are deeply rooted in the nation's history and traditions.
>
> The trouble is that plaintiffs make no attempt to argue that physician assisted suicide, even in the case of terminally ill patients, has any historic recognition as a legal right.

Id. at 83 (internal citations omitted). Accordingly, the district court concluded "that the type of physician assisted suicide at issue in this case does not involve a

fundamental liberty interest protected by the Due Process Clause of the Fourteenth Amendment." *Id.* at 84.

Turning to the equal protection issue, the district court identified a reasonable and rational basis for the distinction drawn by New York law between the refusal of treatment at the hands of physicians and physician assisted suicide:

> [I]t is hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device. The State has obvious legitimate interests in preserving life, and in protecting vulnerable persons. The State has the further right to determine how these crucial interests are to be treated when the issue is posed as to whether a physician can assist a patient in committing suicide.

Id. at 84-85. Accordingly, the court held "that plaintiffs have not shown a violation of the Equal Protection Clause of the Fourteenth Amendment." *Id.* at 85.

DISCUSSION

I. Justiciability

As they did in the district court, the state defendants contend on appeal that this action does not present a justiciable case or controversy. We reject this contention.

In *Babbitt v. United Farm Workers Nat'l Union*, 442 U.S. 289 (1979), the Supreme Court was faced with a constitutional challenge to an Arizona farm labor statute. The Court stated that, when contesting the constitutionality of a state criminal statute, it is not necessary

that the plaintiff first expose himself to actual prosecution. *Id.* at 298. Rather,

> [w]hen the plaintiff has alleged an intention to engage in a course of conduct arguably affected with a constitutional interest, but proscribed by a statute, and there exists a credible threat of prosecution thereunder, he "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief."

Id. (quoting *Doe v. Bolton*, 410 U.S. 179, 188 (1973)). The Court in *Doe* held that plaintiff physicians had presented a justiciable controversy despite the fact that none had been threatened with prosecution. 410 U.S. at 188. The law that the physicians challenged was a criminal statute that directly criminalized the physician's participation in abortion. Accordingly, a sufficiently concrete controversy was presented.

The same principles lead to the conclusion that there is a case or controversy at issue here. Dr. Quill has had a criminal proceeding instituted against him in the past, and the state nowhere disclaims an intent to repeat a prosecution in the event of further assisted suicides. The other two physician plaintiffs also face the threat of criminal prosecution. Like the physicians in *Doe*, they "should not be required to await and undergo a criminal prosecution as the sole means of seeking relief." Finally, under *Doe*, the physicians may raise the rights of their terminally-ill patients. *See id.*

Although District Attorney Morgenthau argues in his brief on appeal that appellants have not shown that they are in any jeopardy of prosecution in New York County, a recent indictment by a New York County grand jury

demonstrates the contrary. A newspaper report printed on December 15, 1995 disclosed the following:

> Yesterday, District Attorney Robert M. Morgenthau of Manhattan announced that a grand jury had indicted [George] Delury, an editor who lives on the Upper West Side, on manslaughter charges for helping his 52-year-old wife, Myrna Lebov, commit suicide last summer.

Carey Goldberg, *Suicide's Husband Is Indicted; Diary Records Pain of 2 Lives*, N.Y. Times, Dec. 15, 1995, at B1.[1] The physician plaintiffs have good reason to fear prosecution in New York County.

II. Substantive Due Process

Plaintiffs argue for a right to assisted suicide as a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment. This Clause assures the citizenry that any deprivation of life, liberty or property by a state will be attended by appropriate legal processes. However,

> despite the language of the Due Process Clause[ ] of the . . . Fourteenth Amendment[ ], which appears to focus only on the processes by which life, liberty, or property is taken, the cases are legion in which th[at] Clause[ ] ha[s] been interpreted to have substantive content, subsuming rights that to a great extent are immune from . . . state regulation or proscription. Among such cases are those recognizing rights that have little or no textual support in the constitutional language.

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[1] On March 15, 1996, Delury pleaded guilty to second-degree attempted manslaughter. Pam Belluck, *Man Will Get Prison Term for Helping His Wife Kill Herself*, N.Y. Times, Mar. 16, 1996, at 23, 26.

Bowers v. Hardwick, 478 U.S. 186, 191 (1986).

Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937). Fundamental liberties also have been described as those that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977); *see also Griswold v. Connecticut*, 381 U.S. 479, 506 (1965) (White, J., concurring). It is well settled that the state must not infringe fundamental liberty interests unless the infringement is narrowly tailored to serve a compelling state interest. *Reno v. Flores*, 113 S. Ct. 1439, 1447 (1993). The list of rights the Supreme Court has actually or impliedly identified as fundamental, and therefore qualified for heightened judicial protection, include the fundamental guarantees of the Bill of Rights as well as the following: freedom of association; the right to participate in the electoral process and to vote; the right to travel interstate; the right to fairness in the criminal process; the right to procedural fairness in regard to claims for governmental deprivations of life, liberty or property; and the right to privacy. 2 Ronald D. Rotunda & John E. Nowak, *Treatise on Constitutional Law* § 15.7, at 434-36 (2d ed. 1992). The right of privacy has been held to encompass personal decisions relating to marriage, procreation, family relationships, child rearing and education, contraception and abortion. *See Carey v. Population Servs. Int'l*, 431 U.S. 678, 684-85 (1977). While the Constitution does not, of course, include any explicit mention of the right of privacy, this right has been recognized as encompassed by the Fourteenth

Amendment's Due Process Clause. *Id.* at 684. Nevertheless, the Supreme Court has been reluctant to further expand this particular list of federal rights, and it would be most speculative for a lower court to do so. *See* Rotunda & Nowak, *Treatise on Constitutional Law*, *supra*, § 15.7, at 433-37.

In any event, the Supreme Court has drawn a line, albeit a shaky one, on the expansion of fundamental rights that are without support in the text of the Constitution. In *Bowers*, the Supreme Court framed the issue as "whether the Federal Constitution confers a fundamental right upon homosexuals to engage in sodomy and hence invalidates the laws of the many States that still make such conduct illegal and have done so for a very long time." 478 U.S. at 190. Holding that there was no fundamental right to engage in consensual sodomy, the Court noted that the statutes proscribing such conduct had "ancient roots." *Id.* at 192. The Court noted that sodomy was a common law criminal offense, forbidden by the laws of the original 13 states when they ratified the Bill of Rights, and that 25 states and the District of Columbia still penalize sodomy performed in private by consenting adults. *Id.* at 192-93.

As in *Bowers*, the statutes plaintiffs seek to declare unconstitutional here cannot be said to infringe upon any fundamental right or liberty. As in *Bowers*, the right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. *See* Thomas J.

Marzen et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 56-67 (1985). Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. The New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 55 (1994) ("*When Death Is Sought*"). Clearly, no "right" to assisted suicide ever has been recognized in any state in the United States. *See generally* Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 561 (1995); Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Rep., May-June 1993, at 32.

In rejecting the due process-fundamental rights argument of the plaintiffs, we are mindful of the admonition of the Supreme Court:

> Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution.

Bowers, 478 U.S. at 194. The right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death. We therefore decline the plaintiffs' invitation to identify a new fundamental right, in the absence of a clear direction from the Court whose precedents we are bound to follow. The limited

room for expansion of substantive due process rights and the reasons therefor have been clearly stated: "As a general matter, the Court has always been reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area.

III. Equal Protection

According to the Fourteenth Amendment, the equal protection of the laws cannot be denied by any State to any person within its jurisdiction. U.S. Const. amend. XIV, § 1. This constitutional guarantee simply requires the states to treat in a similar manner all individuals who are similarly situated. *See* 3 Rotunda & Nowak, *Treatise on Constitutional Law*, *supra*, § 18.2, at 7. But disparate treatment is not necessarily a denial of the equal protection guaranteed by the Constitution. The Supreme Court has described the wide discretion afforded to the states in establishing acceptable classifications:

> The Equal Protection Clause directs that "all persons similarly circumstanced shall be treated alike." But so too, "[t]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." The initial discretion to determine what is "different" and what is "the same" resides in the legislatures of the States. A legislature must have substantial latitude to establish classifications that roughly approximate the nature of the problem perceived, that accommodate competing concerns both public and

> private, and that account for limitations on the practical ability of the State to remedy every ill. In applying the Equal Protection Clause to most forms of state action, we thus seek only the assurance that the classification at issue bears some fair relationship to a legitimate public purpose.

Plyler v. Doe, 457 U.S. 202, 216 (1982) (internal citations omitted and alteration in original).

The general rule, then, is that state legislation carries a presumption of validity if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). In *Cleburne*, the equal protection issue revolved around a zoning ordinance that required a special use permit for homes for the mentally retarded but not for other multiple-dwelling and care-giving facilities. The Supreme Court resolved the issue as follows:

> Because in our view the record does not reveal any rational basis for believing that the Featherston home [for the mentally retarded] would pose any special threat to the city's legitimate interests, we affirm the judgment below insofar as it holds the ordinance invalid as applied in this case.

Id. at 448. In arriving at this conclusion, the Court rejected the city's claims that the disparate classification was justified by the negative attitudes of property owners in the neighborhood of the proposed facility, the location of the facility across the street from a junior high school and on a 500-year flood plain, concerns about legal responsibility for actions that might be taken by the mentally retarded, or concerns about the size of the facility and the number of occupants. *Id.* at 448-50. The Court carefully examined each of these claims

before finding that there was no acceptable reason for the disparate classification in any of them.

Also found invalid under the Equal Protection Clase for failure to survive rational basis scrutiny was a New Mexico statute providing a partial exemption from he state's property tax for certain honorably discharged eterans. *Hooper v. Bernalillo County Assessor*, 472 U.S. 612 (1985). The exemption was limited to veterans who had served on active duty during the Vietnam War fc at least 90 continuous days and were New Mexico residats before May 8, 1976. In finding the residence requement invalid under the Equal Protection Clause, he Court analyzed the New Mexico statute in light of he following principles: "When a state distributes benefits unequally, the distinctions it makes are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive rational scrutiny if the distinction rationally furthers a legitimate state purpose." *Id.* at 618 (footnote omitted). The Court determined that the distinction made between veterans who arrived in the state prior to May 8, 1976 and those who arrived thereafter bore no rational relationship to the state's declared objectives of encouraging veterans to settle in the state and of rewarding citizens who resided in the state prior to the cut-off date for their military service. *Id.* at 619-20.

As to the first objective, the Court wrote:

> The distinction New Mexico makes between veterans who established residence before May 8, 1976, and those veterans who arrived in the State thereafter bears no rational relationship to one of the State's objectives—encouraging Vietnam veterans to move to New Mexico. The legislature set this eligibility date long after the triggering event

> occurred. The legislature cannot plausibly encourage veterans to move to the State by passing such retroactive legislation.

Id. at 619 (internal citation omitted). As to the second declared objective, the Court noted that a state court may legitimately compensate resident veterans for past services by providing various advantages, but that "the New Mexico statute's distinction between resident veterans is not rationally related to the State's asserted legislative goal." *Id.* at 621-22. The Court held:

> The State may not favor established residents over new residents based on the view that the State may take care of "its own," if such is defined by prior residence. Newcomers, by establishing bona fide residence in the State, become the State's "own" and may not be discriminated against solely on the basis of their arrival in the State after May 8, 1976.

Id. at 623. *See also Zobel v. Williams*, 457 U.S. 55 (1982) (holding that Alaska statute using length of residence as basis for distribution of oil reserve dividends violated Equal Protection Clause.)

While rational basis scrutiny governs judicial review of the constitutionality of legislation in the areas of social welfare and economics, *see Bowen v. Owens*, 476 U.S. 340, 345 (1986), strict scrutiny is the standard of review where a classification "impermissibly interferes with the exercise of a fundamental right or operates to the peculiar disadvantage of a suspect class," *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 312 (1976) (footnotes omitted). Suspect classes are those identified by race, alienage or national origin, *Cleburne*, 473 U.S. at 440, and fundamental rights are those explicitly or implicitly derived from the Constitution itself, *see*

San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33-34 (1973). For the reasons described in Part II, *supra*, the New York statutes prohibiting assisted suicide during the terminal stages of illness do not impinge on any fundamental rights nor can it be said that they involve suspect classifications. Laws subject to strict scrutiny will survive such review only if they are suitably tailored to serve a compelling state interest. *Cleburne*, 473 U.S. at 440.

An intermediate level of scrutiny has been applied in analyzing certain equal protection guarantee violations. To pass this scrutiny, the classification must be substantially related to an important governmental objective. *Clark v. Jeter*, 486 U.S. 456, 461 (1988). This sort of examination has been applied to classifications based on sex or illegitimacy. *Id.*; *see also Kadrmas v. Dickinson Pub. Sch.*, 487 U.S. 450, 459 (1988); *Mississippi Univ. for Women v. Hogan*, 458 U.S. 718, 723-24 (1982). A heightened level of equal protection scrutiny also was applied in *Plyler*, where the Supreme Court struck down a Texas statute withholding from local school districts funding for the education of children not legally admitted into the United States. 457 U.S. at 202.

Applying the foregoing principles to the New York statutes criminalizing assisted suicide, it seems clear that: 1) the statutes in question fall within the category of social welfare legislation and therefore are subject to rational basis scrutiny upon judicial review; 2) New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths; 3) the distinctions made by New York law with regard to such persons do not further any legitimate state purpose; and 4) accordingly, to the extent that the statutes in questions prohibit persons in

the final stages of terminal illness from having assistance in ending their lives by the use of self-administered, prescribed drugs, the statutes lack any rational basis and are violative of the Equal Protection Clause.

The right to refuse medical treatment long has been recognized in New York. In 1914 Judge Cardozo wrote that, under New York law, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body." *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 129 (1914). In 1981, the New York Court of Appeals held that this right extended to the withdrawal of life-support systems. *In re Eichner* (decided with *In re Storar*), 52 N.Y.2d 363, *cert. denied*, 454 U.S. 858 1981). The *Eichner* case involved a terminally-ill, 83-year-old patient whose guardian ultimately was authorized to withdraw the patient's respirator. The Court of Appeals determined that the guardian had proved by clear and convincing evidence that the patient, prior to becoming incompetent due to illness, had consistently expressed his view that life should not be prolonged if there was no hope of recovery. *Id.* at 379-80. In *Storar*, the companion case to *Eichner*, the Court of Appeals determined that a profoundly retarded, terminally-ill patient was incapable of making a decision to terminate blood transfusions. There, the patient was incapable of making a reasoned decision, having never been competent at any time in his life. *Id.* at 380. In both these cases, the New York Court of Appeals recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so.

The Court of Appeals revisited the issue in *Rivers v. Katz*, 67 N.Y.2d 485 (1986) (establishing the right of mentally incompetent persons to refuse certain drugs). In

that case, the Court recognized the right to bring on death by refusing medical treatment not only as a "fundamental common-law right" but also as "coextensive with [a] patient's liberty interest protected by the due process clause of our State Constitution." *Id.* at 493. The following language was included in the opinion:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Id.

After these cases were decided, the New York legislature placed its imprimatur upon the right of competent citizens to hasten death by refusing medical treatment and by directing physicians to remove life-support systems already in place. In 1987, the legislature enacted Article 29-B of the New York Public Health Law, entitled "Orders Not to Resuscitate." N.Y. Pub. Health Law §§ 2960-79 (McKinney 1993). The Article provides that an "adult with capacity" may direct the issuance of an order not to resuscitate. § 2964. "Order not to resuscitate" is defined as "an order not to attempt cardiopulmonary resuscitation in the event a patient suffers cardiac or respiratory arrest." § 2961(17). "Cardiopulmonary resuscitation" is defined as "measures . . . to restore cardiac function or to support ventilation in the event of a cardiac or respiratory arrest." § 2961(4). An elaborate statutory scheme is in place, and it provides, among other things, for surrogate decision-making, § 2965, revocation of consent, § 2969, physician

review, § 2970, dispute mediation, § 2972, and judicial review, § 2973.

In 1990, the New York legislature enacted Article 29-C of the Public Health Law, entitled "Health Care Agents and Proxies." N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993). This statute allows for a person to sign a health care proxy, § 2981, for the purpose of appointing an agent with "authority to make any and all health care decisions on the principal's behalf that the principal could make." § 2982(1). These decisions include those relating to the administration of artificial nutrition and hydration, provided the wishes of the principal are known to the agent. § 2982(2). The agent's decision is made "[a]fter consultation with a licensed physician, registered nurse, licensed clinical psychologist or certified social worker." *Id.* Accordingly, a patient has the right to hasten death by empowering an agent to require a physician to withdraw life-support systems. The proxy statute also presents a detailed scheme, with provisions for a determination that the principal lacks capacity to make health care decisions, for such a determination to be made only by the attending physician in consultation with another physician "[f]or a decision to withdraw or withhold life-sustaining treatment," § 2983, for provider's obligations, § 2984, for revocation, § 2985, and for special proceedings, § 2992, among other matters.

The concept that a competent person may order the removal of life-support systems found Supreme Court approval in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). There the Court upheld a determination of the Missouri Supreme Court that required proof by clear and convincing evidence of a patient's desire for the withdrawal of life-sustaining equipment.

The patient in that case, Nancy Cruzan, was in a persistent vegetative state as the result of injuries sustained in an automobile accident. Her parents sought court approval in the State of Missouri to terminate the artificial nutrition and hydration with which she was supplied at the state hospital where she was confined. The hospital employees refused to withdraw the life-support systems, without which Cruzan would suffer certain death. The trial court authorized the withdrawal after finding that Cruzan had expressed some years before to a housemate friend some thoughts that suggested she would not wish to live on a life-support system. The trial court also found that one in Cruzan's condition had a fundamental right to refuse death-prolonging procedures.

The Missouri Supreme Court, in reversing the trial court, refused to find a broad right of privacy in the state constitution that would support a right to refuse treatment. Moreover, that court doubted that such a right existed under the United States Constitution. It did identify a state policy in the Missouri Living Will Statute favoring the preservation of life and concluded that, in the absence of compliance with the statute's formalities or clear and convincing evidence of the patient's choice, no person could order the withdrawal of medical life-support services.

In affirming the Missouri Supreme Court, the United States Supreme Court stated: "The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. The Court noted that the inquiry is not ended by the identification of a liberty interest, because there also must be a balancing of the state interests and the individual's liberty interests before there can be a determination that con-

stitutional rights have been violated. *Id.* at 279. The Court all but made that determination in the course of the following analysis:

> Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially-delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.

Id.

The Court went on to find that Missouri allowed a surrogate to "act for the patient in electing to have hydration and nutrition withdrawn in such a way as to cause death," subject to "a procedural safeguard to assure that the action of the surrogate conforms as best it may to the wishes expressed by the patient while competent." *Id.* at 280. The Court then held that the procedural safeguard or requirement imposed by Missouri—the heightened evidentiary requirement that the incompetent's wishes be proved by clear and convincing evidence—was not forbidden by the United States Constitution. *Id.* at 280-82.

In view of the foregoing, it seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on

life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs. The district judge has identified "a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." *Quill*, 870 F. Supp. at 84. But Justice Scalia, for one, has remarked upon "the irrelevance of the action-inaction distinction," noting that "the cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.' " *Cruzan*, 497 U.S. at 296-297 (citations omitted and alteration in original) (Scalia, J., concurring). *See also* Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2028-31 (1992) (arguing that there is no distinction between assisted suicide and the withholding or withdrawal of treatment).

Indeed, there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in

bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

A finding of unequal treatment does not, of course, end the inquiry, unless it is determined that the inequality is not rationally related to some legitimate state interest. The burden is upon the plaintiffs to demonstrate irrationality. *See Kadrmas*, 487 U.S. at 463. At oral argument and in its brief, the state's contention has been that its principal interest is in preserving the life of all its citizens at all times and under all conditions. But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. *See In re Quinlan*, 70 N.J. 10, 41, *cert. denied*, 429 U.S. 922 (1976). And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," *Planned Parenthood v. Casey*, 112 S. Ct. 2791, 2807 (1992), when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

A panel of the Ninth Circuit attempted to identify some state interests in reversing a district court decision holding unconstitutional a statute of the state of Washington criminalizing the promotion of a suicide attempt. *Compassion in Dying v. Washington*, 49 F.3d 586 (9th Cir. 1995).[2] The plaintiffs in the Washington case contended for physician-assisted suicide for the terminally-ill, but the panel majority found that the statute prohibiting suicide promotion furthered the following: the interest in denying to physicians "the role of killers of their patients"; the interest in avoiding psychological pressure upon the elderly and infirm to consent to death; the interest of preventing the exploitation of the poor and minorities; the interest in protecting handicapped persons against societal indifference; the interest in preventing the sort of abuse that "has occurred in the Netherlands where . . . legal guidelines have tacitly allowed assisted suicide or euthanasia in response to a repeated request from a suffering, competent patient." *Id.* at 592-93. The panel majority also raised a question relative to the lack of clear definition of the term "terminally ill." *Id.* at 593.

The New York statutes prohibiting assisted suicide, which are similar to the Washington statute, do not serve any of the state interests noted, in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment. Physicians do not fulfill the role of "killer" by prescribing drugs to hasten death any more than they do by disconnecting life-support systems. Likewise, "psychological pressure" can be applied just as much upon the elderly and infirm

[2] On rehearing in banc, the Ninth Circuit vacated the decision of the panel and affirmed the decision of the district court. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996) (in banc).

to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death. There is no clear indication that there has been any problem in regard to the former, and there should be none as to the latter. In any event, the state of New York may establish rules and procedures to assure that all choices are free of such pressures. With respect to the protection of minorities, the poor and the non-mentally handicapped, it suffices to say that these classes of persons are entitled to treatment equal to that afforded to all those who now may hasten death by means of life-support withdrawal. In point of fact, these persons *themselves* are entitled to hasten death by requesting such withdrawal and should be free to do so by requesting appropriate medication to terminate life during the final stages of terminal illness.

As to the interest in avoiding abuse similar to that occurring in the Netherlands, it seems clear that some physicians there practice nonvoluntary euthanasia, although it is not legal to do so. *When Death Is Sought*, *supra*, at 133-34. The plaintiffs here do not argue for euthanasia[3] at all but for assisted suicide for terminally-ill, mentally competent patients, who would self-administer the lethal drugs. It is difficult to see how the relief the plaintiffs seek would lead to the abuses found in the Netherlands. Moreover, note should be taken of the fact that the Royal Dutch Medical Associ-

[3] There are those who use the terms "assisted suicide" and "euthanasia" interchangeably. *See* Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y.L. Sch. L. Rev. 439, 439 n.8 (1992). While euthanasia is derived from the Greek words meaning "good death," *id.* at 441, it seems clear that most states, including New York, make a distinction between the two acts. *See When Death Is Sought*, *supra*, at 63. In euthanasia, one causes the death of another by direct and intentional acts. *Id.* Accordingly, euthanasia falls within the definition of murder in New York. *See* N.Y. Penal Law § 125.25(1) (McKinney 1987).

ation recently adopted new guidelines for those physicians who choose to accede to the wishes of patients to hasten death. Under the new guidelines, patients must self-administer drugs whenever possible, and physicians must obtain a second opinion from another physician who has no relationship with the requesting physician or his patient. Marlise Simons, *Dutch Doctors to Tighten Rules on Mercy Killings*, N.Y. Times, Sept. 11, 1995, at A3.

Finally, it seems clear that most physicians would agree on the definition of "terminally ill," at least for the purpose of the relief that plaintiffs seek. The plaintiffs seek to hasten death only where a patient is in the "final stages" of "terminal illness," and it seems even more certain that physicians would agree on when this condition occurs. Physicians are accustomed to advising patients and their families in this regard and frequently do so when decisions are to be made regarding the furnishing or withdrawal of life-support systems. Again, New York may define that stage of illness with greater particularity, require the opinion of more than one physician or impose any other obligation upon patients and physicians who collaborate in hastening death.[4]

[4] For example, the state might take steps to assure the competence of prescribing physicians by imposing education and training qualifications, including pain management; it may require the establishment of local ethics committees as resources for physicians faced with questions relating to requests for lethal medications; it could specify the information to be furnished to the patient to ascertain that the patient's choice is a fully voluntary one; it might require consultations with other physicians for further diagnosis and prognosis in regard to the patient's illness, for psychiatric evaluation, and for evaluation of pain control possibilities; it may provide a time delay between a request for lethal medication and the prescription in order to allow a time for reflection; and it may suggest some sort of notification to the patient's family.

Recently, a group of physicians known as "Physicians for Mercy" proposed ten guidelines for doctor-assisted suicide. *Doctors Offer Some Support to Kevorkian: Urge 10 Guidelines in Assisting Suicide*, N.Y. Times, Dec. 5, 1995, at A21. These guidelines call for a physician who assists in suicide, called an "obitiatrist," to refer his patients to a psychiatrist, a specialist in the patient's specific illness, and, if necessary, a specialist in pain management, before acting at the behest of a mentally competent person with an incurable affliction. *Id.* "Physicians for Mercy" has decided to call the practice of physician assisted suicide "patholysis," a term coined by Dr. Jack Kevorkian, who has assisted in more than two dozen suicides. *Id.* However, Dr. Kevorkian's assistance has not been rendered exclusively to those beset by terminal illnesses. Bruce Fein, *The Right to Determine One's Exit from Life*, Wash. Times, Jan. 23, 1996, at A14.

The New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest.

CONCLUSION

We reverse the judgment of the district court and remand for entry of judgment in favor of the plaintiffs in accordance with the foregoing. No costs are awarded to either side. *See* Fed. R. App. P. 39(a).

CALABRESI, *Circuit Judge*, concurring in the result:

The Court today strikes down the New York statutes prohibiting assisted suicide insofar as they apply to "terminally ill, mentally competent patients, who would self-administer drugs." It does so because it finds these statutes to be in violation of the Equal Protection Clause of the Fourteenth Amendment since they are not "ratio-

nally related to a legitimate state interest." *Ante* at 20 (citing *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985)). At the same time, the Court declines to hold that these statutes violate the Due Process Clause of the Fourteenth Amendment, because "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design." *Ante* at 18.

Recently the Ninth Circuit, sitting *en banc*, held that analogous laws violated the fundamental Due Process rights of terminally ill patients. *Compassion in Dying v. Washington*, No. 94-35534, 1996 WL 94848 (9th Cir. Mar. 6, 1996) (*en banc*). The Ninth Circuit recognized that Equal Protection arguments for invalidity were "not insubstantial," but did not discuss them in view of its Due Process holding. *Id.* at *39 n.139.

I agree with the Court that these statutes cannot stand. But I do not believe that the history of the statutes, and of New York's approach toward assisted suicide, requires us to make a final judgment under either Due Process or Equal Protection as to the validity of statutes prohibiting assisted suicide. What is not ready for decision ought not to be decided. I would therefore leave open the question of whether, if the state of New York were to enact new laws prohibiting assisted suicide (laws that either are less absolute in their application or are identical to those before us), such laws would stand or fall.

Accordingly, I join the Court's result, but write separately to explain my unwillingness to reach the ultimate Due Process and Equal Protection questions.

I. *A Bit of History*

There once was a time when the law and its judges were not called upon to make choices for human beings lying in the twilight between life and death. In the past, many of these decisions were left to individual doctors and their patients. Sometimes, easing of pain melded, not quite imperceptibly, into more. While doctors did not advertise their availability, there often was an understanding (perhaps unspoken), as patients entered into what usually were long-term relationships with physicians, that when the time came doctors would do what was expected of them. Laws prohibiting assisted suicide were on the books. But whether they were ever meant to apply to a treating physician, or whether such doctors were even slightly concerned about them, is unclear and lost in the shadows of time.[1] And despite a web of statutes, and doctors who, understandably, have become increasingly averse to taking risks and responsibilities, that tradition undoubtedly continues today. As the majority demonstrates, however, this fact is not a prescription for judicial silence. *Ante* at 13-15. We must, therefore,

[1] *See* NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 57 (1994) ("No person has been convicted in New York State of manslaughter for intentionally aiding or causing a suicide. . . . The reluctance to bring such cases no doubt rests in part on the degree of public sympathy [such cases] often arouse, and the resulting difficulty of securing an indictment and conviction."); *Compassion in Dying*, 1996 WL 94848, at *17 (footnotes omitted) ("[T]he mere presence of statutes criminalizing assisting in a suicide does not necessarily indicate societal disapproval. That is especially true when such laws are seldom, if ever, enforced. There is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death. . . . Running beneath the official history of legal condemnation of physician-assisted suicide is a strong undercurrent of a time-honored but hidden practice of physicians helping terminally ill patients to hasten their deaths.").

address petitioners' claim that New York's laws are invalid.

The statutes at issue were born in another age. New York enacted its first prohibition of assisted suicide in 1828. The statute punished any individual who assisted another in committing "self-murder" for first-degree manslaughter. Act of Dec. 10, 1828, ch. 20, 4 1828 N.Y. Laws 19 (codified at N.Y. Rev. Stat. pt. 4, ch. 1, tit. 2, art. 1, § 7 (1829)). This prohibition was tied to the crime of suicide, described by one contemporary New York Court as a "criminal act of self-destruction." *Breasted v. Farmers' Loan & Trust Co.*, 4 Hill 73, 75 (Sup. Ct. 1843), *aff'd*, 8 N.Y. 299 (1853).

English authorities had long declared suicide to be murder. *See* 3 EDWARD COKE, INSTITUTES OF THE LAWS OF ENGLAND 54 (London, E. & R. Brooke 1797) (1644); 1 MATTHEW HALE, PLEAS OF THE CROWN 411-18 (London, E. & R. Nutt 1736) (1680); 4 WILLIAM BLACKSTONE, COMMENTARIES ON THE LAWS OF ENGLAND *189 (1769); 3 JAMES FITZJAMES STEPHEN, HISTORY OF THE CRIMINAL LAW OF ENGLAND 104 (1869); William E. Mikell, *Is Suicide Murder?*, 3 COLUM. L. REV. 379, 391 (1903) ("[W]hatever may have been the law before Bracton's time . . . suicide is murder in English law."). And the leading American case echoed these English authorities. *See Commonwealth v. Bowen*, 13 Mass. 356 (1816). In that case, Chief Justice Parker instructed the jury: "Self-destruction is doubtless a crime of awful turpitude; it is considered in the eye of the law of equal heinousness with the murder of one by another. In this offence, it is true the actual murderer escapes punishment; for the very commission of the crime, which the the [sic] law would otherwise punish with its utmost rigor, puts the offender beyond the reach of its

infliction. And in this he is distinguished from other murderers. But his punishment is as severe as the nature of the case will admit; his body is buried in infamy, and in England his property is forfeited to the King." *Commonwealth v. Mink*, 123 Mass. 422, 428 (1877) (reprinting Parker's jury instructions in *Bowen*). *Mink* itself, written by Chief Justice Gray, found that "any attempt to commit" suicide is "unlawful and criminal." *Id.* at 429.

Four years after *Mink*, however, the New York Legislature revised the Penal Code. The new code provided that an intentional *attempt* to commit suicide was a felony with a maximum penalty of two years' imprisonment. Act of July 26, 1881, ch. 676, §§ 174, 178, 3 1881 N.Y. Laws 42-43. But while the Code declared suicide itself to be "a grave public wrong," it imposed no forfeiture because of "the impossibility of reaching the successful perpetrator." *Id.* § 173. The 1881 statute, echoing the earlier 1828 provision, punished assisting a successful suicide as manslaughter in the first degree. *Id.* § 175. The Code also punished assistance in attempted suicide as an unspecified felony. *Id.* § 176.

Whatever may have been the case in other jurisdictions,[2] the 1828 and 1881 statutes prohibited all attempts to assist in a suicide on the theory that such behavior created accessory liability. Thus, because attempted suicide was a crime, assisting in the commission of suicide was also a crime. And the titles of the sections of the 1881 statute manifest these derivative origins; section 175 prohibited "*Aiding* suicide" and section 176 prohibited "*Abetting* an attempt at suicide." *Id.* (emphasis added).[3]

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[2] *See Compassion in Dying*, 1996 WL 94848, at *48-*49 (Beezer, J., dissenting).

[3] The 1937 New York Report of the Law Revision Commission explicitly found that "[t]he history of the [abetting and advising suicide] pro-

Whether these laws applied to a doctor who eased or hastened the death of a terminally ill patient is, of course, quite another matter, and one on which the evidence is scant.[4]

The 1881 scheme was altered in 1919 when the prohibition against attempted suicide (originally found in sections 174 and 178) was removed. Act of May 5, 1919, ch. 414, § 1, 2 1919 N.Y. Laws 1193. The Legislature, nevertheless, left in place the declaration of suicide as a "grave public wrong." *See Hundert v. Commercial Travelers Mut. Accident Ass'n of Am.*, 244 A.D. 459, 460, 279 N.Y.S. 555, 556 (1st Dep't 1935) (per curiam) ("[S]uicide, although recognized as a grave public wrong, is not a crime."). And the prohibition of assisting suicide also remained on the books. But we have found no case in which a physician aiding a person who wished to commit suicide was, in fact, penalized in New York after 1919.

In 1965, the Legislature took the next step and deleted the declaration that suicide was a "grave public wrong."[5]

vision is traceable into the ancient common law when a suicide or *felo de se* was guilty of a crime punishable by forfeiture of his goods and chattels. One who encouraged or aided him was guilty as an accessory to the crime of 'self-murder'. . . ." STATE OF NEW YORK, REPORT OF THE LAW REVISION COMMISSION FOR 1937, at 830 (1937).

4 *See supra* note 1.

5 The 1965 Act did provide that "[a] person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical injury upon himself may use physical force upon such person to the extent that he reasonably believes it necessary to thwart such result." Act of July 20, 1965, ch. 1030, 1965 N.Y. Laws 2355 (codified at N.Y. Penal Law § 35.10(4)). *See Von Holden v. Chapman*, 87 A.D.2d 66, 68, 450 N.Y.S.2d 623, 626 (4th Dep't 1982) (upholding order authorizing forced feeding of John Lennon's murderer, Mark David Chapman, to prevent Chapman from starving himself to death because "[t]he preservation of life has a high social value in our culture").

It, however, left in place redrafted versions of sections 175 and 176 of the 1881 Code, stating: "A person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide," § 125.15(3), and, "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide," § 120.30.[6]

The years since 1965 have brought further erosion in the bases for prohibiting assisted suicide with respect to terminally ill persons. Thus, in 1981, the New York Court of Appeals declared that "a doctor cannot be held to have violated his legal or professional responsibilities when he honors the right of a competent adult patient to decline medical treatment." *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858 (1981). The court applied this principle both to the withdrawal of life-support and to the refusal of blood transfusions. *Id.* at 379-80. Furthermore, in 1986, the court stated: "In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment . . . ." *Rivers v. Katz*, 67 N.Y.2d 485,

6 Why the legislature left the prohibition of assisted suicide in the law, and whether it thought about the issue at all is hard to say. The 1937 Law Revision Report had, in a sense, presaged the event when it said that since New York had removed "all stigma [of suicide] as a crime" and that "[s]ince liability as an accessory could no longer hinge upon the crime of a principal, it was necessary to define it as a substantive offense." REPORT OF THE LAW REVISION COMMISSION, *supra* note 3, at 831. The Commission seemed to have been concerned primarily with those who talked others into killing themselves. It noted the important difference between aiding someone who had a mind-set to commit suicide and the "more dangerous" person "working upon the mind of a susceptible person to induce suicide," *id.* at 832.

493, 495 N.E.2d 337, 341, 504 N.Y.S.2d 74, 78 (1986). Lower courts, understandably, followed suit. *See Delio v. Westchester County Medical Ctr.*, 129 A.D.2d 1, 516 N.Y.S.2d 677 (2d Dep't 1987) ("[T]he common-law right of self determination with respect to one's body also forms the foundation for a competent adult patient's right to refuse life-sustaining treatment even if the effect is to hasten death . . . .").

The New York Legislature itself acted accordingly. In the 1987 Orders Not to Resuscitate Act, it provided that an "adult with capacity" may create an "order not to resuscitate" in the event the patient "suffers cardiac or respiratory arrest." Act of Aug. 7, 1987, ch. 818, § 1, 1987 N.Y. Laws 3140 (codified as amended at N.Y. Pub. Health Law, §§ 2960-2979 (McKinney 1993 & Supp. 1996)). In the 1990 Health Care Agents and Proxies Act, it went further and permitted a competent person to designate an agent who has "authority to make any and all health care decisions on the principal's behalf that the principal could make." Act of July 22, 1990, ch. 752, § 2, 1990 N.Y. Laws 1538 (codified as amended at N.Y. Pub. Health Law § 2982(1) (McKinney 1993)). The statute explicitly stated that choices regarding the withdrawal of artificial nutrition and hydration are within the purview of a health care agent when the wishes of the principal are reasonably known to the agent. N.Y. Pub. Health Law § 2982(2).[7]

[7] The 1990 Act provided the following caution: "This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law." N.Y. Pub. Health Law § 2989(3). The full significance of this section is not clear. It understandably limited the agent to doing those acts to which the principal, on whose behalf the agent is acting, could consent. It also seemed to leave in place the *status quo* both as to those acts, like suicide, which were no longer crimes and those, like assisted

Later, in 1994, the New York Task Force on Life and the Law, a group organized in 1985 at the request of Governor Cuomo and composed of doctors, bioethicists, and religious leaders, among others, prepared a report on the question. The report, in effect, said leave things as they are: permit suicide and attempted suicide, recognize the right of competent terminally ill patients—either on their own or through agents—to order the ceasing of nutrition and hydration and the withdrawal of life support systems, but do not alter the law to permit what petitioners seek today. NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 142-46 (1994). The Legislature received the report and, not surprisingly, took no action, then or since.

From this historical survey, I conclude that 1) what petitioners seek is nominally still forbidden by New York statutes; 2) the bases of these statutes have been deeply eroded over the last hundred and fifty years; and 3) few of their foundations remain in place today.

Specifically:

• The original reason for the statutes—criminalizing conduct that aided or abetted other crimes—is long since gone.

• The distinction that has evolved over the years between conduct currently permitted (suicide, and aiding someone who wishes to die to do so by removing

suicide, which nominally were. But the section did not go further, as New York claims in a letter brief where it says, citing § 2989(3), that "New York's legislature expressly rejected permitting physician assisted suicide." Section 2989(3) did not speak to this any more than it spoke to the legality of suicide.

hydration, feeding, and life support systems) and conduct still prohibited (giving a competent, terminally ill patient lethal drugs, which he or she can self-administer) is tenuous at best.[8]

• The Legislature—for many, many years—has not taken any recognizably affirmative step reaffirming the prohibition of what petitioners seek.

• The enforcement of the laws themselves has fallen into virtual desuetude—not so much as to render the case before us nonjusticiable, but enough to cast doubt on whether, in a case like that which the petitioners present, a prosecutor would prosecute or a jury would convict. And this fact by itself inevitably raises doubts about the current support for these laws.[9]

II. *Constitutional Doubts*

In the case of ordinary legislation none of this would matter much. We regularly uphold laws whose original reason has vanished, whose fit with the rest of the legal system is dubious, whose enforcement is virtually nil, and whose continued presence on the books seems as much due to the strong inertial force that the framers of our constitutions gave to the *status quo* as to any current

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8 *See ante* at 29-34 (the majority opinion's powerful discussion of the weakness of the distinction).

9 We note in passing that a jury in Michigan recently acquitted Dr. Jack Kevorkian after he argued (despite his earlier, quite explicit, publicity and statements) that all he was doing was ending pain. *See* Todd Nissen, *Kevorkian Found Not Guilty in Assisted Suicide Trial*, Reuters, Mar. 8, 1996. We note also that Iowa has just enacted a law forbidding assisted suicide and that this law does not prohibit "the responsible actions of a licensed health professional to administer pain medication to a patient with a terminal illness." *See Gov. Branstad Signs Bill Outlawing Assisted Suicide*, BNA Health Care Daily, Mar. 5, 1996.

majoritarian support. In a different context, I have argued that courts have used subterfuges and aggressive interpretations to rid the system of such laws. *See* GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 163-66, 172-77 (1982). But I have also criticized such judicial action, at least in the absence of express legislative sanction. *See id.; Taber v. Maine*, 67 F.3d 1029, 1039 (2d Cir. 1995).

When legislation comes close to violating fundamental substantive constitutional rights or to running counter to the requirements of Equal Protection, however, there is, as I hope to demonstrate, a long tradition of constitutional holdings that inertia will not do. In such instances, courts have asserted the right to strike down statutes and, before ruling on the ultimate validity of that legislation, to demand a present and positive acknowledgment of the values that the legislators wish to further through the legislation in issue. And so it is to an examination of the substantive constitutional dubiety of the laws before us that I now turn.

There can be no doubt that the statutes at issue come close—at the very least—to infringing fundamental Due Process rights and to doing so in ways that are also suspect under the antidiscrimination principles of the Equal Protection Clause. While differing in emphasis, the various opinions of the Supreme Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), and in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), as well as the *en banc* opinion of the Ninth Circuit in *Companion in Dying*, and the strongly argued majority opinion in this case, make that abundantly clear.

In *Cruzan*, the Court examined whether guardians could order withdrawal of an incompetent patient's life support when, contrary to the requirements of the State of Missouri, there was not clear and convincing proof of the patient's wish to have life support withdrawn. In deciding that the guardians could not so order, the majority opinion noted that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." 497 U.S. at 278. It went on to describe the decision to withdraw life support as "deeply personal" and noted that "[i]t cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment." *Id.* at 281.

Various Justices expanded on this theme. Justice O'Connor, concurring, wrote, "I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions, see *ante*, at 278-79, and that the refusal of artificially delivered food and water is encompassed within that liberty interest. See *ante*, at 279." *Id.* at 287. She then added, "Requiring a competent adult to endure such procedures against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.* at 289. Justice Brennan, joined by Justices Marshall and Blackmun, dissenting, made a similar point: "Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence." *Id.* at 310-11. In turn, Justice Stevens, also dissenting, powerfully noted: "Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental . . . .' " *Id.* at 343.

Even Justice Scalia, who was the only member of the Court to find that no liberty interest was implicated, recognized that such issues touch the essence of our humanity. He argued that the Constitution was silent on the question of whether one had a liberty interest in refusing life support, and that such a right could not be found in our history and tradition. *Id.* at 293-96 (Scalia, J., concurring). He then went on to say: "Are there, then, no reasonable and humane limits that ought not to be exceeded in requiring an individual to preserve his own life? There obviously are, but they are not set forth in the Due Process Clause. What assures us that those limits will not be exceeded is the same constitutional guarantee that is the source of most of our protection—what protects us, for example, from being assessed a tax of 100% of our income above the subsistence level, from being forbidden to drive cars, or from being required to send our children to school for 10 hours a day, none of which horribles are categorically prohibited by the Constitution. Our salvation is the Equal Protection Clause, which requires the democratic majority to accept for themselves and their loved ones what they impose on you and me." *Id.* at 300. Significantly, as the majority today points out, Justice Scalia also made clear that he recognized no sensible difference between assisted suicide (of the sort involved in the case before us) and assisted removal of life support and feeding tubes.

"[T]he cause of death in both cases is the suicide's conscious decision to 'pu[t] an end to his own existence.' " *Id.* at 295-97 (Scalia, J., concurring).

Although the Court in *Cruzan* did not ultimately decide whether a patient had a constitutionally protected right to die, the majority opinion clearly recognized that any infringement of such a liberty interest was at least constitutionally suspect.[10] It said, "Petitioners insist that under the general holdings of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest. Although we think the logic of the cases discussed above would embrace such a liberty interest, the dramatic consequences involved in refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible. But for purposes of this case, we assume that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279.

What is more, the Court in *Cruzan* did not merely "assume" that a liberty interest in refusing life-sustaining medical treatment existed. It found that a prohibition of life-support termination would deprive a patient of that liberty interest. In doing so, the Court noted that

10 Both Justices O'Connor and Scalia joined Chief Justice Rehnquist's opinion, making it an opinion for the Court. Their own concurring opinions, however, gave significantly different glosses to the Court's opinion. *See Cruzan*, 497 U.S. at 287 (O'Connor, J., concurring) ("As the Court notes, the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body. See *ante*, at 278-279"); *id.* at 293 (Scalia, J. concurring) ("While I agree with the Court's analysis today, and therefore join in its opinion, I would have preferred that we announce, clearly and promptly, that the federal courts have no business in this field . . . .").

"determining that a person has a 'liberty interest' under the Due Process Clause does not end the inquiry," and that "whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests." *Id.* at 279 (internal quotation marks and citation omitted). It then "assumed" that when a patient's liberty interest was balanced against Missouri's interest in life, the balance would come out in favor of the patient.

Cruzan never actually struck this balance, of course, because the Court found that Missouri could insist on strong evidentiary requirements to ensure that Cruzan wanted to die, since "the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment," *id.* at 281. But this in no way undermines *Cruzan*'s holding that in determining whether a patient has a constitutional right to die, we are required to "balance" the consequences of the state's prohibition of life-support termination against the state's interest in preserving life. *Id.* at 279.

Cruzan, therefore, teaches us that statutes that interfere with an individual's decision to terminate life are suspect under the Due Process Clause. The right to act on that decision is one that may or may not receive ultimate constitutional protection, however, depending on the power of the state's interests and the clarity with which those interests are expressed. Moreover, as Justice Scalia in his concurrence points out, the Equal Protection Clause also requires courts to examine whether such statutes apply equally to "you and me"—regardless of whether the prohibited activity interferes with a fundamental right or disadvantages a suspect class.

Like *Cruzan*, *Casey* suggests that New York's assisted suicide statutes are of doubtful constitutionality. In

Casey, the Court noted that "[o]ur law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education" and that "the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity." 505 U.S. at 851, 849. In this respect, *Casey* borrowed from Justice Harlan's formulation in *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting), 505 U.S. at 848-49, and defined liberty interests to include choices at the core of human existence. Following Harlan, it stated: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence . . . . Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Id.* at 851.

Today's majority and the Ninth Circuit, *en banc*, in *Compassion in Dying*, go further than the Supreme Court did in *Cruzan* and *Casey*. These circuits—the first to rule on the matter—hold that laws prohibiting physicians from assisting suicide in some circumstances actually violate the Constitution. The majority does so because it can see no valid Equal Protection difference between the so-called "passive" assistance that New York allows and the "active" assistance that New York purports to forbid. The Ninth Circuit, instead, finds a violation of a fundamental Due Process right.[11]

[11] And some distinguished scholars agree. *See, e.g.*, Jed Rubenfeld, *The Right of Privacy*, 102 HARV. L. REV. 737, 794-95 (1989) ("If the decision to live or die is said to be so fundamental to a person that the state may not make it for him, then it is difficult to see on what plausible ground the right to make this decision could be granted to those on life support but denied to all other individuals."). There are, of course, distinguished scholars who disagree. *See, e.g.*, Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 DETROIT MERCY L. REV. 735, 753-60 (1995).

In light of these opinions, I believe that it cannot be denied that the laws here involved, whether tested by Due Process or by Equal Protection, are highly suspect. It is also the case, however, that neither *Cruzan*, nor *Casey*, nor the language of our Constitution, nor our constitutional tradition clearly makes these laws invalid. What, then, should be done?

III. *The Constitutional Remand*

I contend that when a law is neither plainly unconstitutional (because in derogation of one of the express clauses of our fundamental charter or, for that matter, of the more general clauses, as these have been interpreted in our constitutional history and traditions), nor plainly constitutional, the courts ought not to decide the ultimate validity of that law without current and clearly expressed statements, by the people or by their elected officials, of the state interests involved. It is my further contention, that, absent such statements, the courts have frequently struck down such laws, while leaving open the possibility of reconsideration if appropriate statements were subsequently made.

Thus, in *Kent v. Dulles*, 357 U.S. 116, 129 (1958), in striking down a State Department directive limiting citizens' passport rights, the Supreme Court, said: "Where activities or enjoyment, natural and often necessary to the well-being of an American citizen, such as travel, are involved, we will construe narrowly all delegated powers that curtail or dilute them. We hesitate to find in this broad generalized power an authority to trench so heav-

ily on the rights of the citizen. . . . Thus we do not reach the question of constitutionality. We only conclude that § 1185 and § 211a do not delegate to the Secretary the kind of authority exercised here." And in *Greene v. McElroy*, 360 U.S. 474 (1959), in voiding a loyalty-security program that did not provide for confrontation of witnesses, the Court stated: "[Legislative and executive decisions] must be made explicitly not only to assure that individuals are not deprived of cherished rights under procedures not actually authorized, but also because explicit action, especially in areas of doubtful constitutionality, requires careful and purposeful consideration by those responsible for enacting and implementing our laws." *Id.* at 507 (citation omitted)

The same view was expressed even by the great constitutional absolutist, Justice Hugo L. Black. In *Barenblatt v. United States*, 360 U.S. 109 (1959), in dissent, he argued that the authority of the House UnAmerican Activities Committee to investigate communism in education should be limited, "[f]or we are dealing here with governmental procedures which the Court itself admits reach to the very fringes of congressional power. In such cases more is required of legislatures than a vague delegation to be filled in later by mute acquiescence." *Id.* at 139-40 (footnote omitted).[12]

While these earlier cases leaned in part on statutory interpretation or on broad readings of doctrines such as

12 The Court's opinion in *Kent* and Justice Black's dissent in *Barenblatt* relied in part on a pair of delegation opinions by Chief Justice Hughes dating from the 1930s. These were treated as using a similar approach because, in the 1930s, the statutes at issue were at the fringes of congressional power under the Commerce Clause. *See Kent*, 357 U.S. at 129 (citing *Panama Refining Co. v. Ryan*, 293 U.S. 388, 420-30 (1935)); *Barenblatt*, 360 U.S. at 140 n.7 (Black, J., dissenting) (citing *Panama Refining* and *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495 (1935)).

delegation and vagueness, more recent opinions have applied constitutional remands directly.[13] In *Califano v. Goldfarb*, 430 U.S. 199 (1977), for example, Justice Stevens provided the swing vote in the Court's five-to-four decision that the Social Security Act's grant of special benefits to widows was in violation of Equal Protection. He found that the law discriminated "against a group of males [and] is merely the accidental byproduct of a traditional way of thinking about females." *Id.* at 233 (Stevens, J., concurring). Significantly, he went on to say that "[p]erhaps an actual, considered legislative choice would be sufficient to allow this statute to be upheld, but that is a question I would reserve until such a choice has been made." *Id.* at 223 n.9.[14]

13 Interpretation to avoid constitutional questions and undue delegation have proven particularly useful to the Supreme Court as ways of sending back for a second look federal statutes that came close to infringing fundamental rights. These devices, however, are either not available or are problematic when the statute that skates close to a constitutional line is a state law, since both what can and cannot be delegated within a state and how a state statute should be interpreted are paradigmatic issues of state law. *Compare Sweezy v. New Hampshire*, 354 U.S. 234, 254 (1957) (plurality opinion applying a concept akin to undue delegation to find that "[t]he lack of any indications that the legislature wanted the information the Attorney General attempted to elicit from petitioner must be treated as the absence of authority. It follows that the use of the contempt power . . . was not in accordance with . . . due process") *with id.* at 257 (Frankfurter, J., concurring in the result) (disagreeing with plurality on this issue because "whether the Attorney General of New Hampshire acted within the scope of the authority given him by the state legislature is a matter for the decision of the courts of that State, as it is for the federal courts to determine whether an agency to which Congress has delegated power has acted within the confines of its mandate"). In such circumstances, a reconsideration can occur at the behest of a federal court only if that court is willing impose a constitutional remand directly. *See infra* (discussion of *Thompson v. Oklahoma*, 487 U.S. 815 (1988), and *Abele v. Markle*, 342 F. Supp. 800 (D. Conn. 1972)).

14 The other four votes in the majority held that the statute was an invalid discrimination against women. *Califano*, 430 U.S. at 217 (plurality opinion).

The powerful, and telling, concurring opinion by Justice O'Connor in *Thompson v. Oklahoma*, 487 U.S. 815 (1988), which provided the fifth vote to strike down state death penalty laws applicable to minors less than sixteen years of age, did the same thing. The fact that such laws were on the books in many states did not suffice to meet the strictures of the Cruel and Unusual Punishment Clause. The laws may have been there inadvertently or as a result of inertia, and many state legislatures seemed not to have realized that children could be executed under their statutes. Such laws, moreover, were virtually never enforced against minors under sixteen. Hence, the Justice reasoned, they were invalid. But if states reenacted them, consciously and clearly, the Court would then have to consider whether the statutes could actually meet the Clause's requirements. *Id.* at 857 (O'Connor, J., concurring in the judgment).

Perhaps the most dramatic instance of this constitutional remand, or second look, approach occurred in our own Circuit, in a case bearing many similarities to the one before us today. In *Abele v. Markle*, 342 F. Supp. 800 (D. Conn. 1972) ("*Abele I*"), a three-judge district court was asked to examine the constitutionality of a Connecticut statute that banned abortion. Circuit Judge J. Edward Lumbard found the statute to be unconstitutional for reasons later echoed by the Supreme Court in *Roe v. Wade*, 410 U.S. 113 (1973). District Judge T. Emmet Clarie found no violation of due process for reasons akin to those adverted to in today's majority opinion. The key vote was by then-District Judge Jon Newman.

In his landmark opinion, now-Chief Judge Newman found that the Connecticut statute had been passed in 1860 to protect the health of pregnant women, and that

this aim was no longer applicable in 1972 because childbirth endangered a woman's life more than abortion did. *Id.* at 807-09 (Newman, J., concurring). Yet he recognized that other valid grounds for the statute might exist, including, perhaps, the protection of unborn life (*Roe v. Wade* had not yet been decided). Newman pointed out, however, that the statute was not passed to protect unborn life. "If the Connecticut legislature had made [such] a judgment," Newman mused, "the constitutionality of such laws would pose a legal question of extreme difficulty . . . ." *Id.* at 810. Because "that legislative determination has not been shown to have been made," Newman found it "inappropriate to decide the constitutional issue that would be posed" if the Legislature in fact passed a law designed to protect human life. *Id.* And since the statute before him, whatever its basis, raised strong constitutional doubts, Newman nullified the law while explicitly leaving the Legislature free to reconsider the issue.

Judge Newman's opinion is, of course, not binding on us. But it remains an important beacon suggesting what is the correct approach in extremely difficult cases in which neither the Supreme Court, nor constitutional language or tradition, gives clear guidance. It tells us how to deal with situations in which the state interests that might support such statutes can only be inferred from legislative inaction or from long-abandoned legislative motives.

Today, Timothy Quill takes the place of Janice Abele in challenging another statute of nineteenth-century origin. As with the Connecticut abortion law, the rationale for the New York assisted-suicide prohibition has eroded with the passage of time. In the nineteenth century, both suicide and attempted suicide were crimes and assisting

in those crimes was, derivatively, a crime as well. But suicide and attempted suicide are no longer crimes. Nevertheless, the prohibitions on assisted suicide might serve other valid ends. It is possible, for example, to imagine a state in which such statutes were part of an overall approach to the preservation of life that was so all-encompassing that the laws' validity might be upheld despite their infringement of important libertarian individual rights. Our Constitution gives us no more complete dominion over our bodies than it does over our property. *See, e.g., Schmerber v. California*, 384 U.S. 757 (1966) (holding that a state may, over a suspect's protest, have a physician extract blood from a person suspected of drunk driving). In other words, our Constitution does not enact the bodily equivalent of Herbert Spencer's Social Statics. *Cf. Lochner v. New York*, 198 U.S. 45, 75 (1905) (Holmes, J., dissenting). But there is no sign that such an overall "culture of life" reigns in New York State—quite the contrary.

Well before *Roe v. Wade*, New York enacted one of the most permissive abortion laws in the country. *See Roe*, 410 U.S. 113, 147-48 & n.41 (1973). New York recently reenacted the death penalty. *See* Act of Mar. 7, 1995, ch. 1, § 2, 1995 N.Y. Laws 1 (McKinney's) (codified at N.Y. Penal Law § 60.06 (McKinney's Supp. 1996)). As far as I know, no New York Legislature has seriously considered requiring individuals to give their blood, bone marrow or other organs, to keep those who need transplants alive. Indeed, such an idea would strike many as bizarre science fiction. Nearer to hand, the right to demand to die, as and when one wishes, has been recognized in New York for all those on feeding or hydration tubes or on other life support devices. All this the majority opinion demonstrates beyond peradventure.

Various *amici* for the respondents argue that the New York assisted suicide laws consciously adopt their particular vision of what life and death should be. *Amicus* United States Catholic Conference, for example, insists that suicide is antithetical to freedom, that it is not voluntary and that it is linked to psychiatric illness. But there is no reason to believe that New York has accepted these arguments. If it had, one would expect that New York would prohibit attempted suicide and that it would, for example, aggressively discourage suicide by the terminally ill, through legislative declarations defining it to be a "grave public wrong" or through some other means.

Other *amici* contend that the difference between what they call "active" assisted suicide (making lethal drugs available to those terminally ill who would self-administer them) and what they call "passive" behavior (actively removing life supports or feeding tubes, on demand, so that the patient may die) is fundamental. Even if I were to accept the distinction in the face of the powerful arguments made against it both by the majority today and by Justice Scalia in his *Cruzan* concurrence, there is no reason to believe that New York has consciously made such a judgment. Certainly New York has never enacted a law based on a reasoned defense of the difference.

The Attorney General of New York contends that its Legislature has, in fact, made just such a distinction by its inaction, by its failure to remove the prohibitions before us today. It left these in place after the prohibition on what could be called "passive" assisted suicide had been abrogated. Leaving aside the difficulties involved in arguing that legislative *inaction* should be given the *same* weight as legislative *action* in supporting the view that medical *action* and medical *inaction* are funda-

mentally *different*, the argument will not do. As the majority points out, we have not been given any clear statements of possible interests that the state actually believes would be served by the distinction. In their absence, how can we say that the distinction, which is anything but obvious, and which results in severe harm to the ability of some, but not all, individuals to determine crucial life and death choices for themselves, is mandated by the state's fundamental needs? And if the state does not affirmatively tell us what it wishes to put on the other side of the scale, how can we make the balance required by *Cruzan* come out any way but in favor of an individual's freedom to choose between life and death? Whether under Equal Protection, or Due Process, then, the absence of a recent, affirmative, lucid and unmistakable statement of why the state wishes to interfere with what has been held by the Supreme Court to be a significant individual right, dooms these statutes.

I take no position on what I would hold were such an affirmative statement forthcoming from the state of New York. In the wake of *Furman v. Georgia*, 408 U.S. 238, 239-40 (1972) (per curiam), which in effect sent all of the then-existing death penalty laws back for a second look by the states, the Supreme Court (rightly or wrongly) upheld most of the somewhat modified and subsequently enacted death penalty laws. *See Gregg v. Georgia*, 428 U.S. 153, 179-81 (1976) (plurality opinion). Conversely, one month after Judge Newman's concurrence in *Abele I*, Connecticut enacted a new anti-abortion law that was based on protecting the life of the fetus. Pub. Act No. 1, 1972 Conn. Acts 593 (May Spec. Sess.) (codified at Conn. Gen. Stat. § 53-30(a)-(b)). And the same panel that had decided *Abele I* (rightly or

wrongly) declared the new law unconstitutional.[15] Either result is possible after a second look in which the state affirms laws that it previously had allowed to remain in force through passivity or inertia.[16] What I do say is that no court need or ought to make ultimate and immensely difficult constitutional decisions unless it knows that the state's elected representatives and executives—having been made to go, as it were, before the people—assert through their actions (not their inactions) that they really want and are prepared to defend laws that are constitutionally suspect.

It is different when the Constitution speaks clearly. When a law violates the plain mandates of the text, history, or structure of the Constitution, no second look is warranted or appropriate. That law *must* fall. Laws that violate the core of the First Amendment and the core of the Takings Clause are but two examples. When that is not the case, when the Constitution and its history do not clearly render a statute invalid, when its validity depends instead, in part, on the strength of the state interests at

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15 *See Abele v. Markle*, 351 F. Supp. 224, 232 (D. Conn. 1972) ("*Abele II*"). Then-District Judge Newman's opinion noted that, "for the author of this opinion," the Legislature's new "statement of legislative purpose makes the issue posed . . . quite different from the issue raised by the challenge to the prior statutes. . . . A statute of this sort, as I previously indicated [in *Abele I*], 342 F. Supp. at 810 and 811 n.18, poses a far more difficult question, one that I did not believe should be decided unless such a statute was enacted." *Id.* at 226 n.4. Judge Newman's opinion was joined by Judge Lumbard, while Judge Clarie dissented. The Supreme Court subsequently vacated the decision in light of *Roe*, 410 U.S. 951 (1973), and remanded the case to the district court. On remand, the same three judges declared the law unconstitutional. *Abele v. Markle*, 369 F. Supp. 807, 809 (D. Conn. 1973) (per curiam).

16 Sometimes, of course, a legislature will not reenact a statute that has been remanded to it, or will reenact it with modifications and limits sufficient to avoid any serious constitutional challenge.

stake, then a second look is not only appropriate, it is, in my view, usually required.

Without a second look by the people, courts are liable to err in either direction. They may uphold and thereby validate[17] (as they all too often have[18]) the infringement of rights upon which the states did not truly wish to encroach. Conversely, they may, ultimately and definitively, strike down laws, believing that the state interests involved are minor, when in fact these interests turn out to be highly significant.[19]

In the end, a constitutional remand does no more than this: It tells the legislatures and executives of the various states, and of the federal government as well, that if they wish to regulate conduct that, if not protected by our Constitution, is very close to being protected, they must do so clearly and openly. They must, in other words, face the consequences of their decision before the people.[20] Unless they do this, they cannot expect courts

17 *See* CHARLES L. BLACK, JR., THE PEOPLE AND THE COURT: JUDICIAL REVIEW IN A DEMOCRACY 52 (1960) ("[T]he Court, through its history, has acted as the legitimator of the government. In a very real sense, the Government of the United States is based on the opinions of the Supreme Court.").

18 *See* Guido Calabresi, *The Supreme Court, 1990 Term—Foreword: Antidiscrimination and Constitutional Accountability (What the Bork-Brennan Debate Ignores)*, 105 HARV. L. REV. 80, 143-45 (1991).

19 *See* Harry Wellington, *Common Law Rules and Constitutional Double Standards: Some Notes on Adjudication*, 83 YALE L.J. 221 (1973); Alexander Bickel & Harry Wellington, *Legislative Purpose and the Judicial Process: The* Lincoln Mills *Case*, 71 HARV. L. REV. 1 (1957); Alexander Bickel, *The Supreme Court, 1960 Term—Foreword: The Passive Virtues*, 75 HARV. L. REV. 40 (1961).

20 In this respect, the notion of a constitutional remand may respond to some of the concerns expressed by the dissenters in *Companion in Dying*. *See Compassion in Dying*, 1996 WL 94848, at *60 (Beezer, J. dissenting) ("Whether the charitable or uncharitable characterization [of physician-assisted suicide] ultimately prevails is a question that must be resolved by the people through deliberative decisionmaking in the voting booth . . . This issue we, the courts, need not—and should not—decide. . . . To declare a constitutional right to physician-assisted suicide would be to impose upon the nation a repeal of local laws."); *id.* at 61 (Fernandez, J., dissenting) ("Like so many other issues, it is one 'for the people to decide.' Our Constitution leaves it to them; it is they and their representatives who must grapple with the riddle and solve it.") (citation omitted); *id.* at 61 (Kleinfeld, J., dissenting) ("The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary. . . . That an issue is important does not mean that the people, through their democratically elected representatives, do not have the power to decide it."). *See also* 1 BRUCE ACKERMAN, WE THE PEOPLE: FOUNDATIONS (1991); CAN. CONST. (Constitution Act, 1982), pt. I (Canadian Charter of Rights and Freedoms) § 33 (containing the *Non-Obstante* Clause that permits legislature to abrogate rights, but only if the legislature explicitly decides to do so).

to tell them whether what they may or may not actually wish to enact is constitutionally permitted.

IV. *Conclusion*

For all of the above reasons, I do not reach the merits in this case—merits that are, as Judge Newman said of those that he also did not reach in *Abele v. Markle*, "of extreme difficulty." 342 F. Supp. at 810. What, after all, are we to make of Margaret Mead's statement, cited in one of the *amicus* briefs, that we should beware of giving those who have the power to heal the right to kill, since anthropologically speaking the distinction between the two is relatively new in our cultures? It is certainly worth pondering. But how does it help us to distinguish between giving doctors the right to remove life support systems and the right of the terminally ill to demand lethal drugs from the same doctors? And how is one to weigh petitioners' claim that if doctors are not allowed to give patients lethal drugs for self-administration, those patients will be forced to commit suicide, legally,

in far more horrendous ways—by hanging, shooting, or gassing themselves? These methods, petitioners assert, are plausibly more dangerous to society and devastating to survivors. But is it really the case that terminally ill patients would take such measures? And which way would it cut, if they did not? These questions, moreover, hardly begin to approach the human tragedies, and the deeply held beliefs, that the issues we would have to decide would require us to explore. No. Unless New York forces us to face such choices head on, by asserting its interest in the prohibitions before us, we should not do so. And this New York has not done.

I would hold that, on the current legislative record, New York's prohibitions on assisted suicide violate both the Equal Protection and Due Process Clauses of the Fourteenth Amendment of the United States Constitution to the extent that these laws are interpreted to prohibit a physician from prescribing lethal drugs to be self-administered by a mentally competent, terminally ill person in the final stages of that terminal illness. I would, however, take no position on whether such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves. I therefore concur in the result reached by the Court.

(11)

No. 95-1858

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS VACCO AND PATAKI

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QUESTIONS PRESENTED

1. Whether, under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, terminally ill, mentally competent patients who do not require artificial life support and who want to commit suicide with the assistance of a physician are similarly situated to terminally ill, mentally competent patients who are or can be kept alive only by means of life-sustaining medical treatment, which they are free to refuse or terminate.

2. Whether a state retains a legitimate interest under the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution in prohibiting physician assisted suicide while allowing terminally ill, mentally competent patients to refuse or discontinue artificial life support.

TABLE OF CONTENTS

PAGE

QUESTIONS PRESENTED i

TABLE OF AUTHORITIES iv

OPINIONS BELOW 1

JURISDICTION 2

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED 2

STATEMENT OF THE CASE 3

SUMMARY OF ARGUMENT 6

ARGUMENT 8

I. TERMINALLY ILL PATIENTS ON LIFE SUPPORT WHO NO LONGER WANT THEIR LIVES SUSTAINED BY ARTIFICIAL MEANS AND TERMINALLY ILL PATIENTS WHO ARE NOT ON LIFE SUPPORT AND WANT TO "HASTEN DEATH" BY COMMITTING SUICIDE ARE NOT SIMILARLY SITUATED 9

A. The Second Circuit's Reliance on *Cruzan* Was Misplaced 9

B. Termination of Life Support and Physician Assisted Suicide Are Legally and Medically Different 11

PAGE

C. The Distinctions Are Grounded in Logic 15

II. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS SUPPORTED BY LEGITIMATE STATE INTERESTS 19

A. New York Has a Legitimate, Indeed Compelling, Interest in the Prohibition of Intentional Killing and the Preservation of Life 20

B. The State Has a Legitmate, Indeed Compelling, Interest in Preventing Abuse and Mistake 27

CONCLUSION 33

TABLE OF AUTHORITIES

Cases PAGE

Addington v. Texas, 441 U.S. 418 (1979) 30

Barber v. Superior Court, 195 Cal. Rptr. 484 (Cal. Ct. App. 1983) 24

Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) 17, 22

City of Cleburne, Texas v. Cleburne Living Center, 473 U.S. 432 (1985) 19, 20, 22

Colyer, In re, 660 P.2d 738 (Wash. 1983) 14

Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir.) (en banc), *cert. granted*, 65 U.S.L.W. 3218 (U.S. Oct. 1, 1996) (No. 96-110) 11, 13, 20

Conroy, Matter of, 486 A.2d 1209 (N.J. 1985) 16, 18

Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) ..... *passim*

Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990) 13

Gardner, In re, 534 A.2d 947 (Me. 1987) 14

Heller v. Doe by Doe, 509 U.S. 312 (1993) 26

Kadrmas v. Dickinson Public Schools, 487 U.S. 450 (1988) 8

McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990) 13, 22

People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994), *cert. denied*, 115 S.Ct. 1795 (1995) 9, 11, 17, 18

Personnel Administrator of Massachusetts v. Feeney, 442 U.S. 256 (1979) 26

PAGE

Plyler v. Doe, 457 U.S. 202 (1982) 8

Quinlan, In re, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976) 13

Quill v. Koppell, 870 F.Supp 78 (S.D.N.Y. 1994), *rev'd sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir.), *cert. granted*, 65 U.S.L.W. 3218 (U.S. Oct. 1, 1996) (No. 95-1858) ..... *passim*

Satz v. Perlmutter, 362 So.2d 160 (Fla. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980) 16

Schloendorff v. Society of New York Hospital, 105 N.E. 92 (N.Y. 1914) 26

Shapero v. Kentucky Bar Association, 486 U.S. 466 (1988) 31

State v. McAfee, 385 S.E.2d 651 (Ga. 1989) 22

Storar, Matter of, 420 N.E.2d 64 (N.Y. 1981) 26

Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) 14, 16

Thor v. Superior Court, 855 P.2d 375 (Cal. 1993) 13, 22

Thornburgh v. American College of Obstetrics & Gynecology, 476 U.S. 747 (1986) 31

United States v. Rutherford, 442 U.S. 544 (1979) 21, 22

United States Constitution

Fourteenth Amendment, § 1 ..... *passim*

Federal Statutes

28 U.S.C. § 1254(1) (1993) 2

PAGE

42 U.S.C. § 1983 (1994) 3

New York Statutes

Penal Law § 120.30 (McKinney 1987) ..... *passim*
§ 125.15(3) (McKinney 1987) ..... *passim*

Penal Law, tit. X, ch. 1, §§ 175, 176 (1882) 25

Pub. Health Law Art. 29-C (McKinney 1993) 25

Pub. Health Law § 2989(3) (McKinney 1993) 12, 25

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PAGE

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1858

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS VACCO AND PATAKI[1]

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Second Circuit (J.A. 215)[2] is reported at 80 F.3d 716 (2d Cir. 1996). The opinion of the United States District Court for the Southern District of New York (J.A. 195) is reported at 870 F.Supp. 78 (S.D.N.Y. 1994).

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[1] Petitioner Robert M. Morgenthau, although separately represented, joins in this brief.

[2] References to the joint appendix filed with this brief are cited as (J.A.).

JURISDICTION

The decision of the United States Court of Appeals for the Second Circuit was rendered, and judgment entered, on April 2, 1996. This Court has jurisdiction to hear this appeal under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The constitutional and statutory provisions involved are the Due Process Clause and Equal Protection Clause of the Fourteenth Amendment to the United States Constitution, and New York Penal Law §§ 125.15(3) and 120.30.

The Fourteenth Amendment provides in pertinent part:

> No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

U.S. Const. amend. XIV, § 1.

Penal Law § 125.15(3) is entitled "Manslaughter in the second degree" and provides in pertinent part:

> A person is guilty of manslaughter in the second degree when . . . (3) He intentionally causes or aids another person to commit suicide. Manslaughter in the second degree is a class C felony.

N.Y. Penal Law § 125.15(3) (McKinney 1987).

Penal Law § 120.30 is entitled "Promoting a suicide attempt" and provides:

> A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony.

N.Y. Penal Law § 120.30 (McKinney 1987).

STATEMENT OF THE CASE

Advocating a radical departure from the established precedents and traditions of the State of New York and of this nation, plaintiffs-respondents ("plaintiffs") brought this case to urge recognition of a constitutional right for terminally ill patients to have the aid of a physician in committing suicide. Plaintiffs are three physicians who, together with three terminally ill patients,[3] commenced suit against the New York Attorney General[4] pursuant to 42 U.S.C. § 1983 to contest the constitutional validity of New York Penal Law §§ 125.15(3) and 120.30, which make criminal the acts of causing or aiding another to commit suicide or to attempt suicide (J.A. 21).

Plaintiffs allege that the "Fourteenth Amendment guarantees the liberty of mentally competent, terminally ill adults with no chance of recovery to make decisions about the end of their lives" (J.A. 26), that the right to assisted suicide is a fundamental right (J.A. 27), and that New York's laws are unconstitutional under the Due Process Clause (J.A. 27). They also assert that because terminally ill people may request the withdrawal of life-sustaining treatment, the prohibition of

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[3] The plaintiff-patients, Mr. William A. Barth, Ms. Jane Doe, and Mr. George A. Kingsley, died by the time the district court rendered its opinion, leaving only the physicians as appellants before the Second Circuit and respondents before this Court.

[4] Former New York State Governor Mario M. Cuomo and Manhattan District Attorney Robert M. Morgenthau were added as parties by amendments to the complaint filed in October 1994. Dennis C. Vacco and George E. Pataki were substituted in the action following their succession to the offices of Attorney General and Governor, respectively, in 1995.

physician assisted suicide violates the rights, under the Equal Protection Clause, of those patients who are terminally ill but are not on artificial life support (J.A. 27). Plaintiffs seek a judgment authorizing physicians to furnish prescriptions for lethal medication to patients, which patients would then self-administer to cause their deaths (J.A. 28).

Suit was commenced in July 1994. In September 1994, plaintiffs moved for a preliminary injunction, in support of which they submitted affidavits that described, in detail, the suffering each plaintiff-patient had endured as a consequence of the illnesses that afflicted them. Patient Barth, in his affidavit (J.A. 96), stated that he suffered from several AIDS-related diseases, including cytomegalovirus, microsporidiosis, pneumonia, cryptosporidiosis, and microbacterium avium. The treatments Mr. Barth employed to combat the symptoms of his illnesses, such as daily infusions and overnight intravenous feeding, themselves caused serious negative side effects. Patient Jane Doe, in her affidavit (J.A. 105), stated that she suffered from thyroid cancer, which by the time of suit had caused a large cancerous tumor to wrap itself around her carotid artery, making it necessary to implant a feeding tube in her stomach which itself caused serious negative side effects. Ms. Doe was unable to take sufficient pain medication to achieve comfort while remaining mentally alert. Patient George A. Kingsley submitted an affidavit (J.A. 99) stating that he was afflicted with AIDS-related diseases including cryptosporidiosis, cytomegalovirus retinitis (leading to blindness in one eye), and toxoplasmosis. Mr. Kingsley self-administered medications through painful injections, and other infusions were administered daily through a tube connected to an artery in his chest.

All three patients expressed in their affidavits a desire for "certain death," to be achieved through the intervention of their physicians (J.A. 98, 102, 108). Fear of exposing their physicians to criminal sanction, however, kept the plaintiff-patients from committing suicide with their doctors' assistance (J.A. 102), while fear of exposing themselves to criminal sanctions kept the plaintiff-physicians from rendering such aid (J.A. 46, 71, 88). All of the plaintiff-patients, during the course of this litigation, died of the underlying diseases that afflicted them. The State of New York did not contest below, nor does it contest now, the depth of the suffering experienced by these plaintiff-patients.

Also submitted to the court below was the affidavit of plaintiff-physician Timothy Quill, M.D., describing the medical interventions which typically take place when patients refuse to continue life-sustaining medical treatment and opining that "[w]hen such patients are mentally competent, they are consciously choosing death as preferable to life under the circumstances that they are forced to live" (J.A. 116). As stated by Dr. Quill, "[w]hile death from dehydration and starvation is acceptable to some of our patients, others ask us why they must endure such an ordeal when it can only end in their death, especially when there are alternatives available that could ease death more humanely" (J.A. 118).

In response to the motion for a preliminary injunction, defendants-petitioners cross-moved for dismissal on the pleadings. In an opinion dated December 15, 1994 (J.A. 195), Chief Judge Griesa of the United States District Court for the Southern District of New York treated the cross-motion to dismiss as one for summary judgment (J.A. 197), and held on the merits that the criminalization of physician assisted suicide involves neither a denial of a fundamental liberty interest protected by the Fourteenth Amendment's Due Process Clause nor a denial of equal protection under that same Amendment (J.A. 207-09).

On appeal, the Second Circuit affirmed that portion of the district court's opinion which found no substantive due process right to assisted suicide, concluding that "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design" (J.A. 233). The court found, however,

that New York's prohibition of physician assisted suicide violates the Equal Protection Clause, holding that physician assisted suicide is no different than the withdrawal of life-sustaining medical treatment, that the State of New York has no legitimate interest that justifies the "prolongation of a life that is all but ended," and that no rational basis exists to support New York's disparate treatment of the two (J.A. 245). On this basis, the court invalidated New York Penal Law §§ 125.15(3) and 120.30 to the extent that those laws impose criminal penalties on physicians who prescribe lethal dosages of medication for their terminally ill, mentally competent patients to self-administer in order to commit suicide (J.A. 249).

A concurring opinion (Calabresi, J.) agreed that the statutes were "constitutionally suspect" but recommended that New York's penal provisions on assisted suicide be sent back to the New York State Legislature on "constitutional remand" for full consideration and a clear articulation of the state interests involved should the Legislature re-enact the statutes (J.A. 265).

On October 1, 1996, this Court granted certiorari, 65 U.S.L.W. 3218 (U.S. Oct. 1, 1996) (No. 95-1858), to decide the equal protection questions presented.

SUMMARY OF ARGUMENT

The Second Circuit erred in concluding that terminally ill patients who exercise a right to forego or withdraw from artificial life support are, for equal protection purposes, similarly situated to those who are also terminally ill, have no equivalent life-sustaining treatment to forego, and want a physician's assistance in committing suicide. As this Court recognized in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), the right to forego treatment derives from the common law right to bodily integrity and freedom from unwanted physical intrusions. The asserted

"right" to physician assisted suicide is, by contrast, a right to demand outside assistance in the taking of one's own life.

The distinction between acts that artificially sustain life and those that artificially end life is reflected in *Cruzan* as well as in the laws of nearly every state, which provide for the refusal or termination of medical treatment but expressly prohibit assistance in suicide. It is also reflected in medical practice and medical ethics, which generally permit withdrawal of treatment but forbid a physician's assistance in a patient's suicide. These legal and medical distinctions are rooted in logical differences between refusal or termination of treatment and assisted suicide.

New York's prohibition of assistance in suicide also withstands equal protection scrutiny because it is rationally related to legitimate state interests. The ban reflects the State's interest in prohibiting intentional killing and protecting human life and its unwillingness to make judgments as to the value of life based on the "quality" of life experienced by its citizens. The Second Circuit's equal protection analysis, although ostensibly limited to terminally ill patients, is not so readily contained and could be employed to extend a right of assisted suicide to patients who are not terminally ill and to those who are not ill at all.

New York's prohibition of assisted suicide also is legitimately related to its interest in protecting vulnerable patients from mistake and abuse. There is a direct correlation between inadequate control of pain in medical treatment and patient requests for suicide. Especially with the advent of managed care and other cost control measures in medicine, there is a danger that the quick death offered by legalized suicide will be preferred to costly treatment and proper pain management, a risk which is enhanced for the poor and the elderly, who are likelier than others to suffer from inadequate pain relief. Moreover, any efforts to establish regulations governing and limiting the practice of assisted suicide are likely to founder

upon the confidentiality of the physician-patient relationship. Regulation of physician assisted suicide will inevitably be a matter of physician self-regulation.

The Second Circuit erred in its equal protection analysis, thereby arrogating to itself the decision that doctors may help their patients kill themselves. The question of whether physician assisted suicide should be prohibited, however, is one of legislative dimension, not constitutional imperative.

ARGUMENT

As the Second Circuit noted (J.A. 234), the Equal Protection Clause requires that " 'all persons similarly circumstanced shall be treated alike,' " but " 'does not require things which are different in fact or opinion to be treated in law as though they were the same.' " *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (citations omitted). Moreover, "[u]nless a statute provokes 'strict judicial scrutiny' because it interferes with a 'fundamental right' or discriminates against a 'suspect class,' it will ordinarily survive an equal protection attack so long as the challenged classification is rationally related to a legitimate governmental purpose." *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 457-58 (1988) (citations omitted). Only a statute that treats "similarly circumstanced" people differently without sufficient justification violates the Equal Protection Clause.

The Second Circuit's equal protection inquiry was conceptually legitimate but analytically flawed. Most importantly, the court failed to recognize that, whether viewed as a matter of precedent in law and practice in medicine or as a matter of logic, competent, terminally ill patients who want a physician's assistance in committing suicide are not similarly situated to their counterparts "who are on life-support systems" (J.A. 243-44). Nor did the court, despite holding correctly that the asserted right to assisted suicide is not

fundamental and thus is subject only to rational basis scrutiny, recognize the rational relationship between New York's statutes criminalizing assisted suicide and the legitimate purposes that underlie those statutes.

POINT I

TERMINALLY ILL PATIENTS ON LIFE SUPPORT WHO NO LONGER WANT THEIR LIVES SUSTAINED BY ARTIFICIAL MEANS AND TERMINALLY ILL PATIENTS WHO ARE NOT ON LIFE SUPPORT AND WANT TO "HASTEN DEATH" BY COMMITTING SUICIDE ARE NOT SIMILARLY SITUATED

The Second Circuit committed a central error when it concluded that terminally ill patients whose lives have been sustained by artificial means but who no longer want such treatment and terminally ill patients who are not on life support and wish to "hasten death" by committing suicide are similarly situated. The legal status of the two groups differs, as does the accepted medical practice with respect to each. Moreover, there are important logical and factual distinctions between "acts that artificially sustain life and acts that artificially curtail life." *People v. Kevorkian*, 527 N.W.2d 714, 728 (Mich. 1994), *cert. denied*, 115 S.Ct. 1795 (1995).

A. The Second Circuit's Reliance on *Cruzan* Was Misplaced

This Court, in its leading decision in this area, in fact has already recognized that the nature of the right that entitles a patient to refuse or terminate artificial life support differs from that of the asserted right of a terminally ill patient to receive assistance in committing suicide. *Cruzan v Director, Missouri Department of Health*, 497 U.S. 261 (1990), presented the question of whether an individual in a persistent vegetative state possesses a substantive due process right to

the withdrawal of life-sustaining medical treatment. While stopping short of declaring a constitutional right to withdraw from such treatment, *see id.* at 279, this Court made clear its belief that such a right, whether or not of constitutional dimension, derives from the common law principle of bodily integrity and the entitlement of the individual to be free from interference with his or her person. The Court noted that "[a]t common law, even the touching of one person by another without consent and without legal justification was a battery." *Id.* at 269. Moreover, "[t]his notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment." *Id.* The "logical corollary" of this requirement "is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 270. *See also id.* at 287 (O'Connor, J., concurring) ("the liberty interest in refusing medical treatment flows from decisions involving the State's invasions into the body"); *id.* at 305 (Brennan, J., dissenting) (equating "freedom from unwanted medical attention" and right "to determine what shall be done with one's own body").

While recognizing the right (whether constitutional or not) to refuse or withdraw from life-sustaining treatment, *Cruzan* nevertheless observed that "there can be no gainsaying" a state's "interest in the protection and preservation of human life," as demonstrated by the fact that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Id.* at 280. At the very moment, then, that it recognized a right to refuse treatment, this Court took pains to acknowledge the power of a state to ban assisted suicide outright. The Court thus demonstrated its understanding that refusal of treatment and assisted suicide are different things, supported by different legal principles.[5]

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[5] *See also* L. Tribe, *American Constitutional Law*, § 15-11, at 1370-71 (2d ed. 1988):

> The right of a patient to accelerate death as such—rather than merely to have medical procedures held in abeyance so that disease processes can work their natural course—depends on a broader conception of individual rights than any contained in common law principles. A right to determine when and how to die would have to rest on constitutional principles of privacy and personhood or on broad, perhaps paradoxical, conceptions of self-determination.

The Second Circuit erred by failing to distinguish the right of "a competent person [to] order the removal of life-support systems" (J.A. 241), which, following *Cruzan*, is based on the right to be free of bodily interference, from the asserted "right" of a terminally ill patient to assistance in suicide. The heavy reliance of the court below on *Cruzan* was misplaced because the right *Cruzan* recognizes does not embrace or suggest the "right" the Second Circuit announced. A person who seeks a physician's help in committing suicide is asserting not a right to be free of unwanted physical intrusions, but a right to insist on outside intervention in achieving a desired end. As *Cruzan* illustrates, the distinction is significant. *Accord Kevorkian*, 527 N.W.2d at 728 ("[i]n *Cruzan*, the Court was able to 'assume' a protected liberty interest in the withdrawal of life-sustaining medical treatment because it was able to distinguish between acts that artificially sustain life and acts that artificially curtail life. . . . [S]ome suggest that this is a distinction without constitutional significance . . . the *Cruzan* majority disagreed and so do we").

B. Termination of Life Support and Physician Assisted Suicide Are Legally and Medically Different

Until the decisions below and in *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir.) (en banc), *cert. granted*, 65 U.S.L.W. 3218 (U.S. Oct. 1, 1996) (No. 96-110), this distinction was universally observed in American law. Thus, at least forty-four states which recognize the right to refuse treatment expressly disapprove of assisted suicide in statutes providing for the exercise of that refusal right,[6] and

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[6] Ala. Code § 22-8A-10 (1990); Alaska Stat. § 18.12.080(f) (1994); Ariz. Rev. Stat. Ann. § 36-3210 (1995 Supp.); Ark. Code Ann. § 20-17-210(g) (1991); Cal. Health & Safety Code § 7191.5(g) (West

at least thirty-five states ban assisted suicide by separate statute.[7]

Supp. 1996); Colo. Rev. Stat. § 15-18-112(1) (1987); Act of July 12, 1982, 63 Del. Laws 821 (1981); Fla. Stat. Ann. § 765.309(1) (West 1996 Supp.); Ga. Code Ann. § 31-32-11(b) (1994); Haw. Rev. Stat. § 327D-13 (1992 Supp.); Idaho Code § 39-152 (Supp. 1996); Ill. Comp. Stat. Ann. ch. 755, §§ 35/9(f), 40/50 (Smith-Hurd 1992); Ind. Code Ann. §§ 16-36-4-19, 16-36-1-12(c), 16-36-1-13, 30-5-5-17(b) (Burns 1993 & Supp. 1996); Iowa Code Ann. §§ 144A.11.6, 144B.12.2 (West 1989 & Supp. 1996); Kan. Stat. Ann. § 65-28.109 (1992); Ky. Rev. Stat. Ann. § 311.639 (Michie/Bobbs-Merrill 1995); La. Rev. Stat. Ann. tit. 40, § 1299.58.10(A) (West 1992); Mass. Gen. Laws Ann. Ch. 201D, § 12 (West 1996 Supp.); Me. Rev. Stat. Ann. tit. 18-A, § 5-813(c) (1995 Supp.); Md. Health-Gen. Code Ann. § 5-611(c) (1994); Mich. Comp. Laws Ann. § 700.496(20) (West 1995); Minn. Stat. Ann. § 145B.14 (West 1996 Supp.); Miss. Code Ann. § 41-41-117(2) (1993); Mo. Ann. Stat. § 459.055(5) (Vernon 1992); Mont. Code Ann. § 50-9-205(7) (1995); Neb. Rev. Stat. § 20-412(7) (1995); Nev. Rev. Stat. Ann. § 449.670(2) (Michie 1991); N.H. Rev. Stat. Ann. § 137-H:13 (1995 Supp.); N.Y. Pub. Health Law § 2989(3) (McKinney 1993); N.C. Gen. Stat. § 90-320(b) (1993); N.D. Cent. Code §§ 23-06.4-01, 23-06.5-01 (1991); Ohio Rev. Code Ann. § 2133.12(D) (Anderson 1994); Okla. Stat. Ann. tit. 63, § 3101.12(G) (West 1996 Supp.); Pa. Cons. Stat. Ann. tit. 20, § 5402(b) (Purdon 1996 Supp.); R.I. Gen. Laws §§ 23-4.10-9(f), 23-4.11-10(f) (1995 Supp.); S.C. Code Ann. § 44-77-130 (Law. Co-op 1993 Supp.); S.D. Codified Laws Ann. § 34-12D-20 (1994); Tex. Health & Safety Code Ann. § 672.020 (Vernon 1992); Utah Code Ann. § 75-2-1118 (1993); Va. Code Ann. § 54.1-2990 (1994); Wash. Rev. Code Ann. § 70.122.100 (1996 Supp.); W. Va. Code § 16-3-10 (1995); Wis. Stat. Ann. § 154.11(6) (West 1989); Wyo. Stat. §§ 3-5-211, 35-22-109 (1994 & Supp. 1996).

[7] Alaska Stat. § 11.41.120(a)(2) (1989); Ariz. Rev. Stat. Ann. § 13-1103(A)(3) (1995 Supp.); Ark. Code Ann. § 5-10-104(a)(2) (1993); Cal. Penal Code § 401 (West 1988); Colo. Rev. Stat. § 18-3-104(1)(b) (1995 Supp.); Conn. Gen. Stat. Ann. § 53a-56(a)(2) (1994); Del. Code Ann. tit. 11, § 645 (1995); Fla. Stat. Ann. § 782.08 (West 1992); Ga. Code Ann. § 16-5-5(b) (1994); Ill. Comp. Stat. Ann. ch. 720, § 5/12-31(a)(2) (Smith-Hurd 1996 Supp.); Ind. Code Ann. § 35-42-1-2.5(b) (Burns 1996 Supp.); Iowa S.F. 2066, to be codified as Iowa Code § 707A.2 (1996 Supp.); Kan. Stat. Ann. § 21-3406 (1995); Ky. Rev. Stat. Ann. § 216.302 (Michie/Bobbs-Merrill 1995); La. Rev. Stat. Ann. tit. 14, § 32.12 (West 1996 Supp.); Me. Rev. Stat. Ann. tit. 17-A, § 204 (1983); Minn. Stat.

Since the very first state decision authorizing termination of life support, *In re Quinlan*, 355 A.2d 647, 655 (N.J.) (recognizing "a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support"), *cert. denied*, 429 U.S. 922 (1976), state courts, like state legislatures, have explicitly recognized a legal distinction between refusal of treatment and assisted suicide. *See, e.g., Thor v. Superior Court*, 855 P.2d 375, 385 (Cal. 1993) ("a necessary distinction exists between a person suffering from a life-threatening disease or debilitating injury who rejects medical intervention that only prolongs but never cures the affliction and an individual who deliberately sets in motion a course of events aimed at his or her demise and attempts to enlist the assistance of others"); *Fosmire v. Nicoleau*, 551 N.E.2d 77, 82 (N.Y. 1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act"); *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) ("there is a substantial difference between the attitude of a person desiring non-interference with the natural con-

Ann. § 609.215 (West 1987 and Supp. 1996); Miss. Code Ann. § 97-3-49 (1994); Mo. Ann. Stat. § 565.023.1(2) (Vernon 1996 Supp.); Mont. Code Ann. § 45-5-105 (1995); Neb. Rev. Stat. § 28-307 (1995); N.H. Rev. Stat. Ann. § 630.4 (1986); N.J. Stat. Ann. § 2C:11-6 (West 1995); N.M. Stat. Ann. § 30-2-4 (1994); N.Y. Penal Law §§ 120.30, 125.15(3) (McKinney 1987); N.D. Cent. Code § 12.1-16-04 (1995 Supp.); Okla. Stat. Ann. tit. 21, §§ 813, 814, 815 (West 1983); Or. Rev. Stat. § 163.125(1)(b) (1993) (although Oregon allows physician-assisted suicide under certain circumstances, *see* Or. Rev. Stat. §§ 127.800-127.897 (1996), assisted suicide remains generally illegal); Pa. Cons. Stat. Ann. tit. 18, § 2505(b) (Purdon 1983); R.I. Pub. Act 96-133, to be codified as R.I. Gen.Stat. tit. 11, ch. 60; S.D. Codified Laws Ann. § 22-16-37 (1988); Tenn. Code Ann. § 39-13-216 (1995 Supp.); Tex. Penal Code Ann. § 22.08 (Vernon 1994); Wash. Rev. Code Ann. § 9A.36.060 (1988); Wis. Stat. Ann. § 940.12 (West 1996). In *Compassion in Dying v. Washington*, 79 F.3d at 793-94, the Ninth Circuit held that the portion of the Washington statute prohibiting assisted suicide "as applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths, violates the Due Process Clause of the Fourteenth Amendment."

sequences of his or her condition and the individual who desires to terminate his or her life by some deadly means either self-inflicted or through the agency of another"); *In re Gardner*, 534 A.2d 947, 955 (Me. 1987) (a "decision to live without artificial life-sustaining procedures would not constitute suicide"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient"); *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) ("[i]n the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide").

The legal distinction between refusal of treatment and suicide is paralleled by a medical distinction. The American Medical Association, the American College of Physicians, and the American Geriatrics Society all "consistently distinguish assisted suicide and euthanasia from the withdrawing or withholding of treatment." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 108 & n.111 (1994). *See also* Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA 2229, 2230-31, 2233 (1992) (while "[t]he withdrawing or withholding of life-sustaining treatment is not inherently contrary to the principles of beneficence and nonmaleficence," assisted suicide "is contrary to the prohibition against using the tools of medicine to cause a patient's death"); American Geriatrics Society Policy Committee, *Voluntary Active Euthanasia Position Statement*, 39 J. Am. Geriatrics Society 826 (1991) (same). Medical ethicists also insist on the difference between termination of treatment and assisted suicide. *See* W. Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139, 2139 (1988) ("[g]enerations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments

(or allowing to die) and active, willful, taking of life"); Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 129 (1987) ("[m]edical tradition and customary practice distinguish in a broadly accepted fashion between the refusal of medical intervention and intentionally causing death by assisting suicide").[8] The rank and file of the medical profession likewise observes the distinction. *See* M. Solomon et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatment*, 83 Am. J. Pub. Health 14, 17 (Jan. 1993) (survey shows 87% of hospital physicians and nurses agree with the statement that "to allow patients to die by foregoing or stopping treatment is ethically different from assisting in their suicide").

C. The Distinctions Are Grounded in Logic

The legal and medical distinctions between refusal or termination of treatment and assisted suicide are not arbitrary. Rather, they are rooted in at least three real logical differences between the two practices. First, they may be distinguished on the basis of intention of both physician and patient. As one expert puts it, a physician who withdraws treatment intends "to cease doing useless and futile or degrading things to the patient when [the patient] no longer stands to benefit from them," whereas a physician who assists a suicide "must, necessarily and indubitably, intend primarily that the patient be made dead." L. Kass, *Ethical Issues in Assisted Suicide*, Testimony Before Oversight Hearing on Assisted Suicide of House Committee on Judiciary, Subcomm. on the Constitution (April 29, 1996) at 16.[9] Similarly, a person who

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[8] The Hastings Center is "America's preeminent institute for the study of medical ethics." E. Larson, *Seeking Compassion in Dying*, 18 Seattle U. L. Rev. 509, 517 (1995).

[9] Assisted suicide is distinguishable from palliative treatment that may result in the patient's death, which is encompassed by the doctrine of "double effect." The intent of palliative treatment is to relieve pain and suffering, even though death may be a possible side effect of the treatment. While medication may, for example, in some cases depress res-

terminates treatment may face death as a likely result, but his purpose may be not death but, for example, the avoidance of invasive medical technology or prevention of treatments that conflict with sincerely-held religious beliefs. By contrast, a person who commits or obtains assistance in committing suicide intends to take his own life; he has a specific intent to die. Several courts have based the distinction between refusal or termination of treatment and assisted suicide on the different intent that underlies each. *See Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (people who refuse life-sustaining treatment "may not harbor a specific intent to die," but may instead "fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering"); *Saikewicz*, 370 N.E.2d at 426 n.11 ("in refusing treatment the patient may not have the specific intent to die"); *Satz v. Perlmutter*, 362 So.2d 160, 162-167 (Fla. Ct. App. 1978) (the fact that the patient "really wants to live, but * * * under his own power," precludes "his further refusal of treatment being classed as attempted suicide"), *aff'd*, 379 So.2d 359 (Fla. 1980).

Refusal or withdrawal of treatment and assisted suicide may also be distinguished based upon the difference between

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piration and thus lead to death, it is administered solely for pain relief, but with the patient's knowledge and acceptance of the risk of death. See Council on Ethical and Judicial Affairs, American Medical Association, *Physician-Assisted Suicide* (Report 8), App. C, at 2 (Dec. 1993); *see also id.* at 3 ("[t]he relief of suffering is an essential part of the physician's role as healer").

Analytically and medically, acceptance of palliative treatment that may result in death is no different from the knowing acceptance of the risk of death that accompanies many medical treatments, such as the risk of death attendant on a quadruple bypass. If the patient's death results from the surgery, the surgeon is not responsible for the death, nor does he intend it, even though it technically occurred at his hands. The indicated treatment—intended for the patient's well-being and undertaken with the patient's informed consent—simply was not successful. J. Arras, *News From the Circuit Courts: How Not to Think About Physician Assisted Suicide*, 2 BioLaw S:171, S:181 (July-Aug. 1996).

action and inaction. As one court has said, assisted suicide involves "affirmative, assertive, proximate direct conduct, such as furnishing" an instrumentality of death, and thus differs from the "presence of a doctor during the exercise of his patient's" right to refuse treatment. *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. Ct. App. 1986). It is true that one member of this Court, on whose opinion the court below relied (J.A. 243), has questioned "the action-inaction distinction," finding no legal difference from the patient's perspective between submitting to death and seeking it. *See Cruzan*, 497 U.S. at 296-97 (Scalia, J., concurring). As applied to the physician, however, the distinction is "deeply rooted in the law of negligence," which distinguishes between "active misconduct" or "misfeasance" and "passive inaction" or "nonfeasance." *Kevorkian*, 527 N.W.2d at 728. *See also* G. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 Seattle U.L. Rev. 473, 479 (1995) ("the duty not to commit a battery does not generate a duty to rescue; a duty not to touch does not generate a duty to render aid"). Although the distinction will not always be clear-cut, there is an obvious moral distinction between "originat[ing] a fatal sequence" and "allow[ing] one to run its course." *See* P. Foot, *Killing and Letting Die*, in *Abortion: Moral and Legal Perspectives* 177, 180 (J. Garfield and P. Hennessey eds., 1984). Assisted suicide, in other words, "involves not *letting* the patient die, but *making* the patient die." S. Carter, *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion* 236 (1993) (emphasis in original). The distinction is honored by the established difference between acting to bring about a death through assisting a suicide and allowing one to occur through refusal or withdrawal of life-sustaining treatment.

Perhaps the clearest distinction underlying the different status of refusal or withdrawal of treatment and assisted suicide is based on causation. A patient who declines or withdraws from life-sustaining treatment is letting nature take its course.

His death is caused by the underlying disease or disorder, not by some intervention unrelated to it. "[T]here must," in other words, "be an underlying fatal pathology if allowing to die is even possible. Killing, by contrast, provides its own fatal pathology." D. Callahan, *The Troubled Dream of Life: In Search of a Peaceful Death* 77 (1993). Numerous courts have recognized this distinction. *See, e.g., Kevorkian*, 527 N.W.2d at 728 ("suicide involves an affirmative act to end a life," whereas refusal or withdrawal of treatment "allows nature to proceed"); *Conroy*, 486 A.2d at 1224 (contrasting "allow[ing] the disease to take its natural course" and "self-inflicted injury").

Contrary to the view of the court below (J.A. 215), this is true regardless of whether the underlying pathology is the organic cause of death or whether it imposes some disability that leads inexorably to death. It is thus of no consequence whether, for example, the withdrawal of Nancy Cruzan's artificial hydration and nutrition led to her death due to "an underlying disease" or to starvation. Her persistent vegetative condition and resulting inability to eat caused her death. By contrast, if she had been injected with a lethal dose of drugs, the drugs alone would have resulted in her death. *See* G. Annas, *The "Right to Die" In America: Sloganeering from Quinlan and Cruzan to Quill and Kevorkian*, 34 Duquesne L. Rev. 875, 895-96 (1996) (distinguishing "real causes of death from the existence of various medical tools that may temporarily substitute for particular bodily functions").

Terminally ill patients who exercise a right to forego life-sustaining medical treatment are thus not in the same position as those who are also terminally ill, have no equivalent life-sustaining treatment to forego, but want a physician's assistance in committing suicide. The right to decline or withdraw from treatment derives from the common law right of bodily integrity. No such right underlies assisted suicide, which involves more than simply being let alone. The law has not treated the two classes of patients as similar, and long-standing medical practices distinguish between the two situations. The distinction, moreover, is supported by logical differences based on intent, causation and action/omission. The Second Circuit accordingly erred in concluding that the patients are "similarly circumstanced" (J.A. 243), and that their different treatment by the law can give rise to an equal protection violation.

POINT II

NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS SUPPORTED BY LEGITIMATE STATE INTERESTS

The case for physician assisted suicide, based as it is on instances of individual suffering, rests on what John Arras has called the "twin pillars of patient autonomy and mercy." J. Arras, *News from the Circuit Courts*, 2 BioLaw at S: 175. Dr. Arras notes:

> Many people advocate legalization [of physician assisted suicide] because they fear a loss of control at the end of life. They fear falling victim to the technological imperative; they fear dying in chronic and uncontrolled pain; and they fear the psychological suffering attendant upon the relentless disintegration of the self. They fear, in short, a bad death.

Id. at S: 174.

Juxtaposed against these real fears, the methodology of equal protection sounds formulaic at best. Nonetheless, as the Second Circuit recognized (J.A. 238), in order to survive equal protection scrutiny, New York's prohibition of assisted suicide need only be "rationally related to a legitimate state interest." *City of Cleburne, Texas v. Cleburne Living Center*, 473 U.S. 432, 440 (1985). Because the New York laws neither involve a suspect classification nor "impinge on personal

rights protected by the Constitution," any stricter scrutiny is inappropriate. *Id.*

Although the Second Circuit found otherwise (J.A. 245), New York's ban on assisted suicide bears an obvious and rational relation to several important state interests, and thus is valid under the Equal Protection Clause. Indeed, the reasons underlying the State's legislative choice to prohibit rather than allow physician assisted suicide are more than legitimate; they are compelling.

A. New York Has a Legitimate, Indeed Compelling, Interest in the Prohibition of Intentional Killing and the Preservation of Life

As this Court observed in *Cruzan*, "a State may properly decline to make judgments about the 'quality' of life a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan*, 497 U.S. at 282.[10] In legislating to prohibit

[10] The Second Circuit asks: "What interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes" (J.A. 245). *See also Compassion in Dying*, 79 F.3d at 820 (state's interest in protecting life "is dramatically diminished if the person it seeks to protect is terminally ill"). But, one article asks, "[w]hy should the state's interest in preserving life diminish as life approaches its end? Are the lives of older persons or the terminally ill less 'valuable' to the state than the lives of those who may live indefinitely? And what is it that makes them less 'valuable'?" T. Marzen et al., *Suicide: A Constitutional Right*? 24 Duquesne L. Rev. 1, 103 (1985). If the basis for the supposedly diminished state interest is the diminished public value of the lives of the terminally ill, then the state likewise has a lessened interest in preserving the lives of "[a]ll 'burdensome,' 'noncontributing' persons—those who are 'valueless' to the state in the same sense as the very ill or old." *Id.* at 104. And if the basis for the diminished state interest instead resides in some notion that it is merciful to let the terminally ill die if they so choose, "then it is even more merciful to legitimize the same choice for many others whose lives may seem . . . equally devoid of meaning or filled with suffering, but will nevertheless be prolonged indefinitely." *Id.*

physician assisted suicide, a state can reasonably balance the societal desire for a state's citizens to achieve a death without prolonged suffering against any weakening of society's prohibition of intentional killing. "That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all are equal." House of Lords, *Report from the Select Committee on Medical Ethics*, Session 1993-94, vol. I at 48. Unquestionably there are individual cases of real suffering, but "individual cases cannot establish the foundation of a policy which would have such serious and widespread repercussions." *Id.* This is an instance in which the "interest of the individual cannot be separated from the interest of society as a whole." *Id.*

The Second Circuit's decision effectively disregards New York's interest in the prohibition of intentional killing and the preservation of life. The decision purports to be carefully proscribed, extending only to the "prescribing [of] medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness" (J.A. 249). Yet predicated as it is on an equal protection framework that finds terminally ill patients "similarly situated" whether or not they are on life support, the very reasoning of the decision reveals its potential application to a far larger portion of the population.

The difficulty of containing the right to "hasten death," once recognized at all, is demonstrated by asking whether the right can readily be limited to the terminally ill. The problem is not merely one of definition, *see Developments in the Law—Medical Technology and the Law*, 103 Harvard L. Rev. 1519, 1644 n.11 (1990) ("[t]here is no generally accepted medical definition of 'terminal' "), or of explaining why a "terminal condition"[11] should have constitutional meaning, *see*

[11] This Court, in *United States v. Rutherford*, 442 U.S. 544 (1979), declined to exempt drugs to be used by terminally ill persons from FDA approval, because "under our constitutional framework, federal courts do not sit as councils of revision, empowered to rewrite legislation in accord

T. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 814-819 (1994). The entire basis for the right, according to the Second Circuit, is the similarity between terminally ill patients on life support and terminally ill patients who are not on life support. It is not merely the terminally ill, however, who have an essentially unqualified right to refuse or terminate life-sustaining treatment. As one state court observed, the right to refuse life-sustaining treatment is not "reserved to those suffering from terminal conditions." *Thor v. Superior Court*, 855 P.2d 375, 387 (Cal. 1993). Other state courts have repeatedly upheld the right of all competent individuals to refuse life-sustaining treatment. *See McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (respirator-dependent quadriplegic may terminate treatment); *State v. McAfee*, 385 S.E.2d 651 (Ga. 1989) (same); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297 (Cal. Ct. App. 1986) (victim of severe cerebral palsy permitted to remove nasogastric feeding tube). *See generally* Y. Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Detroit Mercy L. Rev. 735, 740-43 (1995) ("If personal autonomy and the termination of suffering are supposed to be the touchstones for physician-assisted suicide . . . doesn't someone who must continue to live what *she considers* an intolerable or unacceptable existence *for many years* have an equal—or even greater right to assisted suicide?") (emphasis in original).

Proponents of the right to assisted suicide, including one of the present plaintiff-physicians, have made clear their belief

with their own conceptions of prudent public policy." *Id.* at 555. *Cf. City of Cleburne*, 473 U.S. at 445 (declining to find that mentally retarded persons are a suspect class and stating that "it would be difficult to find a principled way to distinguish a variety of other groups who have perhaps immutable disabilities setting them off from others, who cannot themselves mandate the desired legislative responses, and who can claim some degree of prejudice from at least part of the public at large. One need mention only the aging, the disabled, the mentally ill, and the infirm.").

that it is improper to limit the exercise of this right to the terminally ill. *See* T. Quill, *Death and Dignity* 162 (1993) (it is arbitrary to exclude victims of incurable but not terminal progressive illnesses); Note, *Who Decides If There Is " 'Triumph in the Ultimate Agony?' " Constitutional Theory and the Emerging Right to Die with Dignity*, 37 William & Mary L. Rev. 827, 893-95 (1996) (limiting the right to the terminally ill is constitutionally impermissible). And at least one proponent has acted on that belief. *See* G. Annas, *The "Right to Die" in America*, 34 Duquesne L. Rev. at 891 (describing Dr. Jack Kevorkian's assistance in the suicide of a patient in the early stages of Alzheimer's disease).

A second, separate inquiry moves from the terminally ill who want a physician to "prescrib[e] medications to be self-administered" by a patient (J.A. 249) to those who seek suicide but are unable to self-administer the lethal agents necessary to accomplish the act. Imagine, Professor Kamisar says, a person who is terminally ill and wishes to end her own life, but is physically unable

> to perform the last, death-causing act herself? . . . If the claim that one has, or ought to have, a right to control the time and manner of one's death is well founded—if one who is terminally ill has, or ought to have, the right to make the choice whether or not to go on living until death comes naturally—how can this right be denied to someone simply because she cannot swallow the barbiturates that will bring about death?

Kamisar, *Against Assisted Suicide*, 72 U. Detroit Mercy L. Rev. at 747. In one direction, then, the movement is from the terminally ill to the non-terminally ill; in another, it leads from physician assisted suicide to physician administered active euthanasia.

In addition, if a state approves physician assisted suicide and then also approves voluntary active euthanasia, under an equal protection analysis it may well next countenance non-

voluntary active euthanasia.[12] Many people who are incapable of requesting death might still be regarded as entitled to assistance in suicide. This follows, most obviously, from *Cruzan*, where the Court permitted an inquiry into an incompetent patient's expression of her wishes when she was competent. Under the Second Circuit's decision, if those wishes had included assisted suicide, it is difficult to see what principle would have prevented them from being honored. And in states which invoke a "best interests" standard in making treatment decisions for incompetent patients, *see, e.g.*, *Barber v. Superior Court*, 195 Cal. Rptr. 484, 493 (Cal. Ct. App. 1983) (where the choice the incompetent patient would have made with respect to prolonging his life cannot be ascertained, "the surrogate ought to be guided in his decision by the patient's best interests"), even the failure of an incompetent or never-competent patient to specify his desires with respect to physician assisted suicide will not be an obstacle to the exercise of this "right," for he may be viewed as similarly situated in all important respects to a terminally ill, competent patient who wants to ingest a lethal dose of drugs.[13]

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12 "Nonvoluntary" euthanasia is defined as "the euthanizing of incompetent patients or those who are unable to express their wishes." D. Callahan & M. White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Richmond L. Rev. 1, 42 (1996).

13 The experience of the Netherlands is instructive. While euthanasia is proscribed by the Dutch Penal Code, a series of judicial decisions since 1973 has enabled Dutch physicians to practice euthanasia and assisted suicide under certain circumstances. *See generally* Comment, *Deference to Doctors in Dutch Euthanasia Law*, 10 Emory Internat'l L. Rev. 255 (1996). A survey commissioned by the Dutch government showed that, out of a total of 129,000 deaths, there were 400 cases of assisted suicide, 2300 cases of active voluntary euthanasia, and 1000 cases of nonvoluntary euthanasia, apparently including more than 100 cases in which the patient was mentally competent. P. J. van der Maas et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 The Lancet 669-674 (1991).

Thus, while the holding of the Second Circuit is narrow, the rationale upon which it rests demonstrates the great difficulty in containing the right to "hasten death," once any such "right" is recognized. The result is not only a failure to credit New York's legitimate interest in preventing intentional killing, but is also the improper substitution of a judicial determination for a legislative judgment.

As this Court has noted, a state is not required to equivocate when it articulates its interest in the protection and preservation of human life, but rather may legitimately assert an "unqualified interest" in life's preservation. *Cruzan*, 497 U.S. at 282. In the context of assisted suicide, that is precisely what New York has done. In fact, the State has taken a long and considered look at assisted suicide and at the distinction between assisted suicide and the refusal of treatment, the Legislature having visited the issues in enactments spanning two centuries.[14] The State's most recent statutory mention of assisted suicide came as part of the adoption by the New York Legislature of statutory provisions on health care proxies. N.Y. Pub. Health Law Art. 29-C (McKinney 1993). At that time, the Legislature made clear that nothing being added to the law was "intended to permit or promote suicide, assisted suicide or euthanasia," N.Y. Pub. Health Law § 2989(3) (McKinney 1993), and New York's penal provisions criminalizing assisted suicide were unambiguously left in place and not modified in any form.

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14 In 1788, New York recognized by statute the criminal common law, under which assisting suicide and assisting attempted suicide were crimes. Act of Feb. 21, 1788, ch. 37, § 2, 1788 N.Y. Laws 664, 665. In 1828, New York embodied its prohibition in its Penal Code. N.Y. Rev. Stat. pt. IV, ch. 1, tit.2, art. 1, § 7 (1829). The prohibition remained in place through a revision of the Penal Code in 1881. *See* N.Y. Penal L. tit. X, ch. 1, §§ 175, 176 (1882). The current provision dates from a complete revision, in 1965, of the criminal law in New York. 1965 N.Y. Laws c. 1030, codified at N.Y. Penal L. §§ 125.15(3), 120.30 (McKinney 1987). Under New York law, suicide itself is not a crime.

The substitution by the Second Circuit of its own "quality of life" judgment for that which was legislatively crafted was error. *See Heller v. Doe by Doe*, 509 U.S. 312, 319 (1993) (rational basis review " 'is not a license for courts to judge the wisdom, fairness, or logic of legislative choices,' " nor does it authorize " 'the judiciary [to] sit as a superlegislature' ") (citations omitted). When a legitimate governmental interest underlies a legislative act, the "calculus of effects, the manner in which a particular law reverberates in a society, is a legislative and not a judicial responsibility." *Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 272 (1979). The Second Circuit's approach leaves no room for the quintessentially legislative act of achieving a "pragmatic compromise" between the societal desire "to respect patients' wishes, relieve suffering, and put an end to seemingly futile medical treatment" and the need "to maintain the salutary principle that the law protects all human life, no matter how poor its quality." Kamisar, *Against Assisted Suicide*, 72 U. Detroit Mercy L. Rev. at 758.[15] New York has, for its entire existence, struck the balance by prohibiting assisted suicide, *see* N.Y. Penal Law §§ 120.30, 125.15(3), while preserving for its citizens the common-law right to refuse life-sustaining treatment, *see Matter of Storar*, 420 N.E.2d 64, 70 (N.Y. 1981) (competent adult patient " 'has a right to determine what should be done with his own body' ") (quoting *Schloendorff v. Society of New York Hospital*, 105 N.E. 92, 93 (N.Y. 1914) (Cardozo, J.)). The valuation of human life that underlies this legislative line-drawing is for the people of the State to determine. It is not a function to be preempted by the courts.

[15] The coming debate over the allocation of not just medical resources but resources of all kinds in the face of global overcrowding highlights the dubious, indeed illegitimate, nature of a substitution of judicial judgment for that of the elected representatives of a given state.

B. The State Has a Legitmate, Indeed Compelling, Interest in Preventing Abuse and Mistake

Not only did the Second Circuit neglect the validity of New York's considered legislative judgment, but it also discounted other state interests underlying New York's decision to prohibit physician assisted suicide. One such interest of paramount concern lies in the State's desire to prevent abuse. The New York State Task Force on the Life and the Law[16] explored this question thoroughly in a 1994 report on physician assisted suicide and euthanasia, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, in which it unanimously recommended rejection of proposals to legalize physician assisted suicide,[17] based upon the potential for abuse and mistake.

Among its observations, the Task Force noted:

[16] The New York State Task Force on Life and the Law was convened by Governor Mario M. Cuomo in 1985 to recommend public policy on health care decision-making issues raised by medical advances and new technologies. It is chaired by the State's Commissioner of Health, and its membership includes the State's Commissioner on the Quality of Care for the Mentally Disabled, physicians, nurses, academics, lawyers and representatives of various religious communities. New York State Task Force, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* i (1994). Since its inception, the Task Force has recommended public policy on a number of issues, including determination of death, the withdrawal and withholding of life-sustaining treatment, organ transplantation, the treatment of disabled newborns, and new practices to assist reproduction, and has issued reports and legislative proposals on, among other things, do-not-resuscitate orders and health care proxies. *Id.* at i, vii. *See also* New York State Task Force, *When Others Must Choose: Deciding for Patients Without Capacity* (1992); *Life Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (1987); *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* (1986).

[17] Among the proposals examined by the Task Force in reaching its conclusions was one co-authored by Dr. Timothy Quill, plaintiff herein. New York State Task Force, *When Death Is Sought* at 142.

> Assisted suicide and euthanasia would carry us into new terrain—American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill.

Id. at vii-viii. *See also id.* at viii ("the distinction between the refusal of medical treatment and assisted suicide and euthanasia has not been well-articulated in the broader public debate" and the "often-used rubric of the 'right to die' obscures" what are "critical distinctions"); Tribe, *American Constitutional Law* § 15-11 at 1370 ("[o]nce recognized, rights to die might be uncontainable and might prove susceptible to grave abuse").

As the Task Force stated, "[s]ome decisions to contribute to a patient's death may be well-intentioned but hasty and possibly mistaken. In other cases, patients may be pressured to consent to euthanasia when their care is expensive or burdensome to others." New York State Task Force, *When Death Is Sought* at 99. The Task Force likewise observed "that assisted suicide will be practiced through the prism of social inequality and prejudice that characterizes the delivery of services in all segments of society, including health care. Those who will be most vulnerable to abuse . . . are the poor, minorities, and those who are least educated and least empowered." *Id.* at 125.

As recognized by the Task Force, *id.* at x, research suggests that suicide requests diminish when there is adequate control of pain and other symptoms, *see* K. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Assisted Suicide*, 6 J. Pain & Symptom Management 289, 290 (1991), and "excessive pain, discomfort and anxiety are nearly always examples of inadequate treatment," D. Shew-

mon, *Active Voluntary Euthanasia: A Needless Pandora's Box*, 3 Issues L. & Med. 219, 220 (1987). There is, moreover, evidence indicating that physicians do not always give or know how to give adequate relief of pain. *See* New York State Task Force, *When Death Is Sought* at 43 (only 12% of physicians rate their pain management training as excellent or good). "Particularly with the emergence of cost controls and managed care in the United States, the danger of tempting health care providers to persuade chronic patients to minimize costs by ending it all painlessly is no fantasy." S. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey and the Right to Die*, 44 Am. U. L. Rev. 803, 841 (1995).

Moreover, it is not difficult to imagine that, given the inherent imbalance of power in the doctor-patient relationship, a doctor's suggestion of physician assisted suicide may be viewed not as the presentation of an option but as encouragement. *See, e.g.*, New York State Task Force, *When Death Is Sought* at 122 ("[t]hrough their tone, the encouragement they provide or withhold, and the way they present the information available, physicians can often determine the patient's choice"). This risk, obviously, is exacerbated for those "whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group," and who are likelier than others to suffer from inadequate pain relief. *Id.* at 120, 143. The coercive pressures which could surround the option of assisted suicide as a "medical treatment" cannot be underestimated. If the practice were to gain legal approval, physicians would presumably have a duty to inform patients fully about the option and, in response, some patients would likely feel there would be no alternative but to acquiesce, even if they would prefer to remain alive. *See id.* at 122 ("[e]ven assuming all physicians would act in good faith . . . physicians' recommendations would be a powerful fac-

tor in their patients' choices. Indeed, patients generally do what their doctors recommend").

The Second Circuit was mistaken in suggesting (J.A. 246-248) that New York's interest in protecting vulnerable patients from abuse is identical for patients who require life-sustaining treatment and those who consider physician assisted suicide. If the State prohibited patients from refusing unwanted medical treatment because of concerns about abuse, that could lead to the virtual enslavement of dying patients by tubes and invasive machinery, essentially mandating unwanted bodily interference. There is a difference between forcing invasive treatment on dying patients and helping them to kill themselves. Moreover, the nature and extent of the risk of abuse differs between the two populations. The risk of abuse with refusal of treatment is inherently limited: by definition, only people who require invasive treatment will die after refusing life-sustaining measures. By contrast, the risk of abuse and mistake with assisted suicide applies to every single person to whom the Second Circuit (or any other court) extends the "right."

Nor is the Second Circuit realistic in believing that New York can "establish rules and procedures to assure that all choices are free of such pressures" (J.A. 247). For one thing, there is the danger of error by physicians. No matter how many "safeguards" are proposed to accompany any legalization of assisted suicide, in practice all schemes of human governance are fallible, and mistakes are inevitable. The determination of who will be a "candidate" for assisted suicide depends upon a host of threshold decisions which must be made by physicians, all subject to fallible judgments, including determinations as to who is truly terminally ill, who is competent, who has a chance of recovery, and what is the proper course of pain management. All of these judgments are subject to the risk of misdiagnosis of the underlying illness or the failure to identify depression or other compromised mental state. *Cf. Addington v. Texas*, 441 U.S. 418, 430 (1979)

(the "nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations").

Moreover, the physician-patient relationship "is conducted in private and protected by the ethical and legal requirements of confidentiality," and is therefore "inherently inconsistent with on-site procedural regulation." Callahan & White, *The Legalization of Physician-Assisted Suicide*, 30 U. Richmond L. Rev. at 66. *See also* T. Quill, *Death and Dignity: A Case of Individualized Decisionmaking*, 324 New Eng. J. Med. 691 (1991) (first exposing Dr. Quill's suicide assistance, which would otherwise have remained unknown). As a practical matter, regulation of physician assisted suicide will be largely self-regulation by physicans. Callahan & White, *The Legalization of Physician Assisted Suicide*, at 10. *See Shapero v. Kentucky Bar Association*, 486 U.S. 466, 481 (1988) (O'Connor, J., dissenting) (courts should defer to "legislative function" of states in area of professional regulation); *Thornburgh v. American College of Obstetrics & Gynecology*, 476 U.S. 747, 803 (1986) (White, J., dissenting) ("the government is entitled not to trust members of a profession to police themselves").

In reaching a determination to prohibit physician assisted suicide, a state may also rely on the fact that this practice is not generally accepted by physicians themselves as an appropriate medical procedure. Despite the fact that the plaintiff-physicians in this case assert that assisted suicide is, in some cases, ethically proper from their own point of view, and even assuming that some other physicians would agree, assisted suicide by physicians remains contrary to the established ethics of the medical profession. *See* Council on Ethical and Judicial Affairs, American Medical Association, *Decisions Near the End of Life*, 267 JAMA at 2233 ("physician-assisted suicide, like euthanasia, is contrary to the prohibition against using the tools of medicine to cause a patient's death"). There is simply no medical consensus in support of the practice, which has uniformly been regarded, to the present day, as out-

side the boundaries of acceptable medical procedure. *See* Council on Ethical and Judicial Affairs, American Medical Association, *Physician-Assisted Suicide*, 10 Issues L. & Med. 91 (1994) (physician assisted suicide is inconsistent with the physician's professional role). It surely is not irrational for the State, as here, to recognize, in law, a limitation which is ethically and clinically established by the profession itself.

In essence, "[t]o make assisted suicide legal is to require each individual to justify (at least to herself) the decision to remain alive." Kreimer, *Does Pro-Choice Mean Pro-Kevorkian?*, 44 Am. U. L. Rev. at 816. The State of New York has a legitimate interest, as a matter of public policy, in shielding its citizens from the burden of performing this calculus. New York's choice to avoid the risks and complications inherent in embarking on the path opened by any legalization of assisted suicide is a permissible judgment for a state confronted with an issue of enormous complexity and far-reaching effect. New York's interests in preserving life and avoiding the abuses that arise in connection with assisted suicide are legitimate, and the relationship between these interests and a prohibition on assisted suicide is obvious. It is only to those who view the case as the Second Circuit did, and seek a justification for the difference between physician assisted suicide and what that court called "suicide through the withdrawal of life-sustaining treatment" (J.A. 246), that this will not be enough. Because it is erroneous, as a matter of history, law, medicine and logic, to treat these practices as the same thing, terminally ill individuals who wish to commit suicide with a physician's assistance are not similarly situated to terminally ill individuals who refuse or terminate life-sustaining medical treatment, and New York's different treatment of the two groups does not implicate the Equal Protection Clause.

CONCLUSION

Wherefore, Petitioners respectfully pray that the judgment of the United States Court of Appeals for the Second Circuit, entered April 2, 1996, be reversed insofar as it invalidated on equal protection grounds two New York State penal provisions that prohibit assisted suicide in all forms. That portion of the Second Circuit's decision which concluded that there is no fundamental liberty interest under the Due Process Clause to secure assistance in committing suicide should be upheld.

Dated: Albany, New York
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IN THE

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, ET AL.,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., ET AL.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR RESPONDENTS

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QUESTION PRESENTED

May a State constitutionally criminalize a physician's prescription of medication requested by a competent, terminally ill patient in the final stages of dying, who seeks that medication to end her life without intolerable suffering, when the State permits terminally ill patients intentionally to end their lives by having their physicians withdraw or withhold essential medical treatment, including nutrition and hydration?

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF AUTHORITIES v

INTRODUCTION 1

STATEMENT OF THE CASE 4

1. The Facts 5

2. The Law of the State of New York 10

3. The Proceedings Below 17

SUMMARY OF ARGUMENT 18

ARGUMENT 19

I. THE FOURTEENTH AMENDMENT PROTECTS THE LIBERTY AT ISSUE IN THIS CASE 19

A. This Court has Articulated a Principled Approach for Defining the Liberty Protected Under the Fourteenth Amendment 22

B. A Principled Interpretation of the Constitution Requires Protection of the Liberty At Issue in This Case 24

C. The *Cruzan* Decision, Too, Compels Recognition of the Patients' Fourteenth Amendment Liberty ... 28

D. Recognition of the Liberty Involved Here Does Not Require Taking the Approach That Led to Much of the Criticism of *Roe* v. *Wade* 32

II. ALTHOUGH THIS LIBERTY CAN BE CLOSELY REGULATED, THE STATE'S ABSOLUTE BAN IMPOSES AN UNDUE BURDEN ON ITS EXERCISE 33

A. The Legitimate Interests Put Forward by Petitioners Cannot Justify The Challenged Laws 35

B. The Only Rationales That Adequately Explain New York Law are Impermissible Bases for Imposing Such Suffering on the Dying Patient 42

III. THE LINES DRAWN BY THE STATE OF NEW YORK ARE ARBITRARY AND IRRATIONAL AND SO VIOLATE THE EQUAL PROTECTION CLAUSE 44

A. The Distinction Between Withdrawal of Life-Sustaining Treatment and the Provision of Life-Ending Medication, As Drawn By New York Law in the Context of Intentionally Death-Causing Behavior, is Not Rational 45

B. The Distinction Between Terminal Sedation and Prescription of Life-Ending Medication is Not Rational 48

CONCLUSION 50

TABLE OF AUTHORITIES

Cases: **Page**

Allegheny Pittsburgh Coal Co. v. *County Commission of Webster County*, 488 U.S. 336 (1989) 45, 48

Brockett v. *Spokane Arcades, Inc.*, 472 U. S. 491 (1985) 13

Carey v. *Population Services International*, 431 U. S. 678 (1977) 50

City of Ladue v. *Gilleo*, 114 S.Ct. 2038 (1994) 35

City of Cleburne v. *Cleburne Living Center*, 473 U.S. 432 (1985) 45

Clark v. *Jeter*, 486 U.S. 456 (1988) 36

Colorado Republican Campaign Committee v. *FEC*, 116 S. Ct. 2309 (1996) 14, 45, 46

Compassion in Dying v. *Washington*, 79 F.3d 790 (9th Cir.) (en banc), cert. granted *sub nom. Washington* v. *Glucksberg*, No. 96-110 17

Cruzan v. *Director, Mo. Dept. of Health*, 497 U. S. 261 (1990) ..... *passim*

Delio v. *Westchester County Medical Center*, 516 N.Y.S. 2d 677 (App. Div. 1987) 10, 12

Eichner v. *Dillon*, 426 N.Y.S.2d 517 (App. Div. 1980), aff'd with modifications, 420 N.E.2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981) 13

Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 38, 44, 45

Cases — Continued: **Page**

Fargo Women's Health Organization v. *Schafer*, 507 U.S. 1013 (1993) 35

Florida Bar v. *Went For It, Inc.*, 115 S.Ct. 2371 (1995) 43

44 Liquormart, Inc. v. *Rhode Island*, 116 S.Ct.1495 (1996) 43

Fosmire v. *Nicoleau*, 551 N.E. 2d 77 (N.Y. 1990) 11, 37

Grace Plaza of Great Neck, Inc. v. *Elbaum*, 588 N.Y.S. 2d 853 (App. Div. 1992) aff'd, 623 N.E.2d 513 (N.Y. 1993) 11

Griswold v. *Connecticut*, 381 U.S. 479 (1965) 23, 27

Hooper v. *Bernalillo County Assessor*, 472 U.S. 612 (1985) 45

In re Kemmler, 136 U. S. 436 (1890) 49

In re Quinlan, 355 A.2d 647 (N.J.), cert. denied, 429 U. S. 922 (1976) 1

In the Matter of Lydia Hall Hospital, 455 N.Y.S. 2d 706 (Sup. Ct. Nassau County 1982) 12

Louisiana v. *Resweber*, 329 U. S. 459 (1947) 49

Loving v. *Virginia*, 388 U.S. 1 (1967) 27

Matter of Storar, 420 N.E. 2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981) 12

Cases — Continued: **Page**

Michael H. v. *Gerald D.*, 491 U.S. 110 (1989) 27

Moore v. *City of East Cleveland*, 431 U.S. 494 (1977) 28

New York v. *United States*, 505 U.S. 144 (1992) 43

Nordlinger v. *Hahn*, 505 U.S. 1 (1992) 48

Norman v. *Reed*, 502 U.S. 279 (1992) 48

Ollman v. *Evans*, 750 F. 2d 970 (D.C. Cir 1984), cert. denied, 471 U.S. 1127 (1985) 31

Palko v. *Connecticut*, 302 U.S. 319 (1937) 20

Pierce v. *Society of Sisters*, 268 U.S. 510 (1925) 20

Planned Parenthood of Central Missouri v. *Danforth*, 428 U. S. 52 (1976) 10

Planned Parenthood of Southeastern Pennsylvania v. *Casey*, 505 U. S. 833 (1992) ..... *passim*

Plyler v. *Doe*, 457 U.S. 202 (1982) 44, 48

Poe v. *Ullman*, 367 U.S. 497 (1961) 22

Reed v. *Reed*, 404 U.S. 71 (1971) 44, 45

Reno v. *Flores*, 505 U.S. 292 (1993) 21, 33

Ridden v. *Thrall*, 26 N.E. 627 (N.Y. 1891) 28

Rochin v. *California*, 342 U.S. 165 (1952) 22, 25

Roe v. *Wade*, 410 U. S. 113 (1973) 32

Cases — Continued: **Page**

Romer v. *Evans*, 116 S. Ct. 1620 (1996) 45

Sable Communications v. *FCC*, 492 U.S. 115 (1989) 40

Schloendorff v. *Society of New York Hospital*, 105 N.E. 92 (N.Y. 1914) 25

Thompson v. *Oklahoma*, 487 U.S. 859 (1988) 48

United States v. *Virginia*, 116 S. Ct. 2264 (1996) 48

Van Holden v. *Chapman*, 450 N.Y.S. 2d 623 (App. Div. 1982) 11, 37

Washington v. *Harper*, 494 U.S. 210 (1990) 25

Washington v. *Yakima Indian Nation*, 439 U.S. 463 (1979) 18

Constitutional Provisions:

U.S. Const. Amend. VIII 49

U.S. Const. Amend. XIV ..... *passim*

Statutes:

New York Penal Law § 35.10[4] 11

New York Penal Law § 120.05(5) 16

New York Penal Law § 120.30 10

New York Penal Law § 125.15(3) 10, 38, 50

Statutes — Continued: **Page**

New York Public Health Law § 2961 21

New York Public Health Law § 2964 38

New York Public Health Law § 2982(2) 48

New York Public Health Law § 2989 48

Miscellaneous:

Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374 ..... 40, 41

Back, *Physician Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 922 (1996) 39

Margaret Battin, *The Least Worst Death* (1994) 41

Benrubi, *Euthanasia- The Need for Procedural Safeguards*, 326 New Eng. J. Med. 197 (1992) 31

Cherny & Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, J. of Palliative Care 31 (1994) 8, 15, 16

Cotton, *Medicine's Position is Both Pivotal and Precarious in Assisted Suicide Debate*, 273 JAMA 363 (1995) 41

Archibald Cox, *The Role of the Supreme Court in American Government* (1976) 32

Miscellaneous — Continued: **Page**

Freund, *Storms Over the Supreme Court*, 69 A.B.A.J. 1474 (1983) 33

Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe* v. *Wade*, 63 N.C.L. Rev. 375 (1985) 26, 32, 33

Ginsburg, *Speaking in A Judicial Voice*, 67 N.Y.U. L. Rev. 1185 (1992) 4

Maurice B. Gordon, *Aesculapius Comes to the Colonies* (1949) 32

The New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994) 16, 17

Richard Posner, *Age and Old Age* (1995) 39

Preston, *Physician Involvement in Life-Ending Practices*, 18 Seattle L. Rev. 531 (1995) 31

Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Arch. Intern. Med. 1785 (1996) 15, 16

Roy, *Need They Sleep Before They Die?*, 6 J. Palliative Care 3 (1990) 15

Truog, *et al.*, *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678 (1992) 15, 16, 26

Miscellaneous — Continued: **Page**

van der Maas, *et al.*, *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New. Eng. J. Med. 1699 (1996) 41, 42

INTRODUCTION

Seven years after the argument in *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U.S. 261 (1990) — and two decades after *In re Quinlan*, 355 A.2d 647 (N.J.), cert. denied, 429 U.S. 922 (1976) — this Court is once again required to rule on laws that touch on fundamental issues of life and death. This case requires the Court to determine whether a State may forbid a terminally ill, mentally competent adult who is in the process of dying to end her own intolerable suffering, pain and physical disintegration by obtaining, within the context of the doctor-patient relationship, a prescription for medication that will allow her to end her life.

The law of New York evinces no blanket policy against a physician assisting such a terminally ill person in dying. Once a person reaches the final stages of life, New York always allows — as it sometimes does not for those whose conditions are reversible — the physician's termination of life-sustaining procedures, including the provision of food and water, even when the patient seeks such termination for the specific purpose of bringing about a merciful death. And for those dying patients willing to endure it, the State permits a procedure known as "terminal sedation" in which doctors induce a state of continuing unconsciousness — a "barbiturate coma" — wherein the patient is denied nutrition and hydration until he is dead. What the State does *not* permit is the provision of prescription drugs that would afford, to the dying patient who is suffering, a death that is certain, humane, and within his own control.

There can be no doubt about the profound nature of the liberty at issue in this case. The person who is dying in intolerable pain or torment faces "suffering [that] is too intimate and personal for the State to insist" that she must bear it. *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 852 (1992). In many of our religions and cultures, bearing such suffering at the end of life is seen as an "ennobl[ing]" act, involving pain that should — or indeed must — be borne "with . . . pride." *Id.* Many of us would never choose to take life-ending drugs, even were we terminally ill, debilitated and suffering intolerably on the edge of death. Nonetheless, in the United States the decision whether to die a death marked by such suffering must, to the degree fate and medicine permit, be left to the individual.

This is particularly true when suffering occurs in a life already artificially extended — as so many lives are today — through the use of modern technology. The Court recognized this in *Cruzan*, explicitly acknowledging the constitutional liberty of a "seriously ill or dying" patient who is being given food and water by artificial means such as a feeding tube — there, a woman in a persistent vegetative state — to instruct that such sustenance be withheld in order to hasten death. See *Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) (recognizing this liberty); see *id.* at 305 (Brennan, J., joined by Marshall and Blackmun, JJ., dissenting) (same); *id.* at 343-344 (Stevens, J., dissenting) (same); see also *id.* at 279 (opinion of the Court) ("the logic of [our prior] cases . . . embrace[s] . . . a liberty interest" in avoiding "artificially delivered food and water essential to life"). Just as "[a] seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions," *id.* at 288 (O'Connor, J., concurring), so a person who is suffering intolerably while dying, having been brought to this point by chemotherapy, an organ transplant, or some other technological advance, may well during her artificially prolonged death "feel a captive" of the State within the prison house of her own body.

Constitutional protection for the liberty asserted here is also compelled by "consideration of the alternative." *Casey*, 505 U.S. at 859. As the Court has made clear, the Liberty Clause protects the right to make certain "important decisions." *Id.* Protection of a choice either inheres or it does not — regardless of the *direction* in which the individual ultimately will seek to exercise it. With an aging population and increasingly fierce competition over medical resources, if there is no protected liberty on the part of a dying, terminally ill patient to decide whether or not to endure further pain or suffering, then the State may just as readily prohibit the provision of life-*extending* treatment to such patients as it may prohibit their receipt of life-*ending* medication. Cf. *id.* ("If . . . the woman's interest . . . had not been recognized . . . the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it . . . ."). Petitioners chillingly foreshadow such a circumstance when they argue that "[t]he coming debate over the allocation of . . . medical resources . . . highlights the . . . illegitimate nature of a substitution of judicial judgment for that of

the elected representatives of a given state." Pet. Br. 26 n. 15.

Recognition of a dying patient's liberty, within the doctor-patient relationship, to request (and to decide whether or not to use) a prescription for life-ending medication does not imply — as petitioners and their *amici* worry it might — any general "right to die," or "right to suicide." The liberty for which respondents seek recognition, like Nancy Cruzan's liberty acknowledged by this Court six years ago, can exist only in truly hopeless cases. Just as Nancy Cruzan, when conscious, would not have been opting for "suicide" in deciding to end a life that would include no meaningful cognition at all, so a patient in the final stages of dying is not committing suicide when choosing to avoid only unbearable, consciousness-filling pain or suffering. Only in such cases is there a protected liberty because only in such cases does the patient face solely a choice of *how* to die, not a choice between death and the myriad possibilities of future life.

Nor would a "right" to involuntary euthanasia — if such a horrific thing could be imagined — follow from the liberty that respondents seek to vindicate. That liberty follows from recognition of the basic rights to human dignity and bodily autonomy. It would be a profound sacrilege to these rights for a person's life ever to be taken involuntarily by another. Indeed, it was precisely the importance of ensuring that such a decision be the individual's own that led this Court in *Cruzan*, addressing the case of a woman in a vegetative state who was no longer competent, to permit the State "to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements." 497 U.S. at 281.

Nor by any means do respondents seek to prohibit all state regulation in this area. Quite the contrary. Close regulation is required for many of the reasons put forward by petitioners and their *amici*. There is no doubt that power over life and death is subject to serious abuse — whether death is brought about by providing a lethal substance, or by disconnecting life-support machines. The state has compelling reasons to regulate closely *all* decisions intended to cause death, or taken with knowledge that they are more likely to hasten death than to extend life. This Court need not and should not make in this case what many have viewed as the mistake of *Roe* v. *Wade* — peremptorily pre-empting all state regulation

designed to advance society's important interests in this area. See, *e.g.*, Ginsburg, *Speaking in A Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1199 (1992).

The legal regime put in place by New York, however, is not a constitutional means of serving these interests. To begin with, the complete criminal prohibition of the prescription of life-ending drugs for mentally competent, terminally ill patients who are dying in unendurable pain and suffering unduly burdens those patients' constitutionally protected liberty.

Further, the State has not chosen a means of regulation that reasonably advances its asserted goals. For on the other side of the line drawn by the State — the permissible withdrawal of essential nutrition, hydration, respiration, kidney dialysis or other treatment for the purpose of bringing about death for those who are suffering intolerably in the process of dying — doctors are virtually unregulated. The line drawn by New York fatally undermines its claim that it has crafted its law to protect life in all circumstances or to prevent mistake or abuse.

Indeed, the only rationale that can explain the line drawn by New York is that the State prefers to send the (false) message that it does not tolerate *any* assistance in dying, despite the indisputable fact that physician assistance in dying (both lawful and unlawful) in fact goes on today. See Br. of Coalition of Hospice Professionals for Affirmance 15-17. The line drawn by New York serves only the impermissible purpose of permitting doctors to bring about death while maintaining plausible deniability — to the public at large, often to their patients and, perhaps, sometimes to themselves and one another.

But our nation is built upon the rule of law, not winks and nods. The State can have no cognizable interest in perpetuating a system that depends for its legitimacy on a gap between written and enforced law, especially if that gap makes it difficult for a patient to discuss honestly with her doctor what that doctor is doing with her body and, perhaps, her very life.

STATEMENT OF THE CASE

This action for declaratory and injunctive relief was decided on a motion for summary judgment. The facts are not in dispute; they

are contained in the pleadings and declarations filed in the District Court. See Pet. App. 65a.[1]

1. The Facts

The original plaintiffs were three physicians, Timothy E. Quill, Samuel G. Klagsbrun, and Howard A. Grossman, and three mentally competent terminally ill patients, Jane Doe, George Kingsley, and William A. Barth. An understanding of the intolerable pain and suffering that confronts such patients is the appropriate starting point for consideration of this case. Their declarations are set out in full at JA 106-108 (Jane Doe), JA 100-102 (George Kingsley) and JA 97-98 (William Barth). The declaration of Jane Doe, who was dying of thyroid cancer, gives a sense of their suffering:

> I am 76 years old and am a retired physical education instructor. . . . I also hold a Masters Degree in High School Guidance Counseling, which I earned from Queens College during the 1960s while I worked and cared for my children. I am widowed and have two grown children. I have always enjoyed an active and independent lifestyle. I have been a leader in my current retirement group school program and active in civic affairs.
>
> . . . . I have a large cancerous tumor which is wrapped around the right carotid artery in my neck and is collapsing my esophagus and invading my voice box. The tumor has significantly reduced my ability to swallow and prevents me from eating anything but very thin liquids in extremely small amounts. The cancer has metastasized to my pl[e]ural cavity

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[1] References to the decisions of the District Court and the Court of Appeals, as reprinted in the Appendix to the Petition for Certiorari, are styled "Pet. App. ___a." References to the Joint Appendix are styled "JA___." References to petitioners' brief in the Second Circuit are styled "Pet. Br. in CA2 at ___." References to the Brief in Opposition to the Petition for Certiorari are styled "Cert. Opp. ___." References to the Brief of Petitioners Vacco and Pataki are styled "Pet. Br. ___." References to the Brief of the United States as *amicus curiae* supporting petitioners are styled "Govt. Br.___." References to briefs *amicus curiae* are styled either "Br. of [the party] ___" or "[Party] Br. ___." References to briefs filed in *Washington* v. *Glucksberg*, No. 96-110, are identified by inclusion in the citation of the phrase "in *Glucksberg*."

and it is painful to yawn or cough. . . .

. . . . Because the tumor causes extreme difficulty in swallowing, I am constantly choking on my own saliva and mucous. At this time, I can no longer swallow sufficient food to nourish myself. It was recently recommended that I have a feeding tube surgically implanted into my stomach through which to receive nutrition and hydration. In early July 1994 I had the tube implanted and have suffered serious problems as a result. I have not tolerated the tube feeding well. . .

. . . . I take a variety of medications to manage the pain. . . . It is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state.

I have experienced a variety of adverse side effects with each treatment regimen, including i) terrible scarring inside my throat and neck from surgery and radioactive iodine; ii) burning and swelling in my neck . . . and nausea from beam radiation; and iii) severe pain, vomiting, nausea and pressure associated with tube feeding.

I have pursued medical treatment since the time my cancer was originally diagnosed to the present time. . . . At this time, it is clear to me, based on the advice of my doctors, that I am in the terminal phase of this disease. It has been explained to me and I understand that there are no cures.

At the point at which I can no longer endure the pain and suffering associated with my cancer, I want to have drugs available for the purpose of hastening my death in a humane and certain manner. I want to be able to discuss freely with my treating physician my intention of hastening my death through the consumption of drugs prescribed for that purpose.

. . . . I believe it is my right to die peacefully and comfortably when I am terminally ill and suffering intolerably. I believe it is partly religious freedom and partly the pursuit of liberty and happiness guaranteed me by the United States Constitution. . . .

People should not be asked against their will to suffer unnecessarily in the process of dying when medical science could provide a humane death. To withhold such choice, and the means to exercise it, from those who are suffering is to deny me my right to live and die humanely. I see it as

unnecessarily cruel and inhumane to deny me this option. It is also inhumane to my loved ones, my family, to require them to watch helplessly as I am forced to endure such suffering.

JA 106-108 (paragraph numbers omitted).

George Kingsley, a 48-year old publishing executive dying from AIDS, submitted a declaration that described some of his suffering. He had "almost no immune system function," was going blind, and had several illnesses including "toxoplasmosis, a parasitic infection which has caused lesions to develop on my brain." JA 100. He took a number of prescribed medications daily that caused "constant negative side effects." These included "painful cramping, extreme gas with bloating and a total loss of appetite." One medication "[is infused] daily . . . for an hour through a Hickman tube," which "is connected to an artery in my chest, prevents me from ever taking showers, and makes simple routine functions burdensome." JA 100-101.

George Kingsley declared:

I know what it is like to lose control over one's life because of AIDS. I have witnessed the excruciating process of dying from AIDS many times over the past several years. One of my best friends recently died after an extended period of suffering in the final stages of AIDS. This friend desired to exercise the choice of hastening his death but did not have the means to do so humanely. The sound of him crying out in pain still echoes in my memory. I could do nothing to help him and he could do nothing to help himself.

My informed, rational choice is that my death from AIDS, when I reach the point where there is nothing more that medical science can do to halt the advance of my disease and I am living with intolerable pain and suffering, be as swift, painless and dignified as possible. I want to be able to hasten my own death in my own home, in a certain and humane way, surrounded with the people I love helping me make my passing comfortable and meaningful. I do not want my loved ones to watch me suffer needlessly.

JA 101-102 (paragraph numbers omitted).

The declaration of William Barth, a 28-year old former magazine

fashion editor, who was also dying of AIDS, was a virtual litany of suffering. He described his treatment for an opportunistic cancer with "radiation and chemotherapy," a virus "in my stomach and colon which caused severe diarrhea, fevers and wasting," one "parasitic infection for which there is effectively no treatment" which caused "significant additional wasting," a second "parasitic infection which has caused severe diarrhea, sometimes producing 20 stools a day, extreme abdominal pain, nausea and additional significant wasting," and from which "I have begun to lose bowel control," and, finally, "a form of tuberculosis which has caused yet additional wasting, fevers and night sweats." JA 97-98.

He described some of the treatment regimes to which he was subjected. One "required daily three hour home infusions." A second, begun after he "contracted AIDS-related pneumonia . . . was so extremely toxic that I vomited with each infusion." JA 97.

He concluded:

> . . . . While I have tolerated some [nightly intravenous] feedings [to attempt to stop the wasting], I am unwilling to accept this for an extended period of time. . . . I can no longer endure the pain and suffering . . . and I want to have drugs available for the purpose of hastening my death.

JA 98.

Palliative medication is of course available to ease many patients' physical pain. But it is undisputed that for others, especially those dying of some forms of cancer and those particularly near death, it may be impossible to relieve their excruciating pain or other physical symptoms. JA 45 (Declaration of Timothy Quill, M.D.); Cherny & Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31 (1994). In addition, some patients may be unable to receive relief from pain because of their violent physical or psychological reactions to high doses of opiates. Palliative medication also has no effect on the suffering that may be brought on by a patient's own anguish, physical degeneration and loss of dignity. JA 46 (Quill Declaration); Cherny & Portenoy at 31. Further, at levels at which it may be effective, such medication may have the effect of impairing mental acuity. See JA 107 (Doe Declaration). Many patients find — especially near the end — that they cannot obtain

the required level of pain relief before losing whatever clarity of mind is otherwise left to them for communicating with loved ones, praying, or coming to terms with their impending death. Although these patients may be prepared to die, they are confronted instead only with intolerable suffering — the suffering of their own pain or of opiate-induced oblivion. See JA 45 (Quill Declaration).

All three of the named patient-plaintiffs died before the district court rendered its decision. JA 198. Significantly, "[t]he State of New York did not contest below, nor does it contest now, the depth of the suffering experienced by these plaintiff-patients." Pet. Br. 5.

The physician-plaintiffs alleged that they each "trea[t] patients who are terminally ill and experience chronic, intractable pain and/or intolerable suffering," and that "in the regular course of [their] medical practice" some of these patients "request assistance in the voluntary self-termination of life." JA 160-161 (Amended Complaint). Each alleged, and petitioners do not contest, that "[u]nder certain circumstances it would be consistent with the standards" of his "medical practice to assist these patients in their decision to hasten death through the prescription of medications," and that this assistance represented the only "certain and humane" manner in which these patients could die. *Id.*

Each physician-plaintiff filed a declaration describing the type of "medical treatment . . . I seek to be able to give my patients." JA 116 (Supp. Dec. of Dr. Quill); JA 121 (Supp. Dec. of Dr. Klagsbrun); JA 123 (Supp. Dec. of Dr. Grossman). Each declared that he sought the ability to "fulfill my professional obligations," by being permitted "to prescribe drugs, if and when medically and psychiatrically appropriate," JA 116; JA 121; JA 123, for his competent, terminally ill patients who wanted to be able to take them in order to prevent "prolonged suffering . . . if and when their suffering becomes intolerable." JA 190 (Second Supp. Dec. of Dr. Quill); JA 192 (Second Supp. Dec. of Dr. Klagsbrun); JA 194 (Second Supp. Dec. of Dr. Grossman). Each physician-plaintiff sued not only on his own behalf, but on behalf of his mentally competent, terminally ill patients with "chronic intractable pain and/or intolerable suffering," who seek "to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs" in order to "avoid continued suffering and a lingering, painful death." See JA 158-163

(Amended Complaint).[2]

2. The Law of the State of New York

The law of New York provides that "[a] person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide." N.Y. Penal Law § 125.15(3). It also provides that "[a] person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." N.Y. Penal Law § 120.30. The interaction of these criminal statutes with end-of-life medical decisions under New York law requires some description.

Petitioners suggest that under New York law the refusal of life-sustaining medical treatment, including nutrition and hydration, has nothing to do with suicide — that it merely involves exercise of the right to "avoi[d] unwanted bodily intrusion." Pet. Br. 30; *id.* at 11, 13-19. But that is not so. To be sure, the refusal of life-sustaining treatment, or a request for its withdrawal, is not *generally* treated by New York law as "suicidal" even if it will foreseeably (or, indeed, inevitably) end in death. To reach this result, New York law utilizes a legal fiction concerning intent. See, *e.g.*, *Delio* v. *Westchester County Medical Center*, 516 N.Y.S. 2d 677, 692 (App. Div. 1987) ("[S]uicide requires a specific intent to die which has generally been found lacking in patients who refuse artificial life-sustaining medical treatment. Instead, a person's desire to have artificial life-support systems terminated evinces only an intent to live free of unwanted mechanical devices and permit the processes of nature to run their course.") (citations omitted).

Nonetheless, persons who are neither terminally ill nor suffering from an incurable condition that renders cognitive life impossible

[2] Plaintiffs Doe, Kingsley and Barth, and these other patients will be referred to collectively as the "patient-plaintiffs." One of the physician-plaintiffs "has had a criminal proceeding instituted against him in the past," Pet. App. 15a. The Second Circuit concluded the physician-plaintiffs here "fac[e] the threat of prosecution," that they may raise the rights of their patients, and that therefore there is a justiciable controversy. Pet. App. 15a. Accord *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 62 (1976). The death of the named patient-plaintiffs thus does not affect the justiciability of this cause.

(*e.g.*, a persistent vegetative state) may be forced to accept life-sustaining medical treatment under certain circumstances. New York's law *will* inquire into their intent to the extent that, if the injury that led to the need for treatment is found to be self-inflicted or the refusal of treatment or request for withdrawal is found to be motivated by a desire to die, the refusal or request for withdrawal may be treated as a suicidal act and hence denied. See *Fosmire* v. *Nicoleau*, 551 N.E.2d 77, 82 & n. 2 (N.Y. 1990) (right of young, otherwise healthy mother who had just delivered by caesarian section to refuse life-saving blood transfusion that would have "completely restore[d her] health" upheld only because "the injury here was not self-inflicted nor does the patient want to die"); see also *Van Holden* v. *Chapman*, 450 N.Y.S.2d 623, 625, 626-627 (App. Div. 1982) (mentally competent adult has no right to refuse nutrition "intravenously or by means of a nasal gastric tube" when his intent is to starve himself to death).

In these latter circumstances, a doctor who assisted the person by, for example, withdrawing essential medical treatment at that person's request would be subject to prosecution under the assisted suicide laws just as if he had provided a lethal prescription. While "merely declining medical care, even essential treatment, is not considered a suicidal act or indication of incompetence," *Fosmire*, 551 N.E.2d at 82, "[t]he State will intervene to prevent suicide," *id.* (citing *inter alia* N.Y. Penal Law § 35.10[4]).[3]

This is by no means illogical. The intentional and nonconsensual disconnection or termination of life-sustaining treatment by a physician would clearly amount to murder under state law. See *Grace Plaza of Great Neck, Inc.* v. *Elbaum*, 588 N.Y.S.2d 853, 857 (App. Div. 1992), aff'd, 623 N.E.2d 513 (N.Y. 1993). Similarly, assisting one whose specific intent was to kill himself by the disconnection or termination of some life-sustaining treatment to which he happened temporarily to be connected could violate New York's law against aiding in suicide. Cf. U.S. Catholic Conference,

[3] New York Penal Law § 35.10[4] provides that "[a] person acting under a reasonable belief that another person is about to commit suicide . . . may use physical force upon such person to the extent that he reasonably believes it necessary to prevent such result."

et al. Br. 20-21.

The situation is very different for those patients who are "fatally ill with no reasonable chance of recovery," see *Matter of Storar*, 420 N.E.2d 64, 66 (N.Y.), cert. denied, 454 U.S. 858 (1981), who are receiving life-sustaining treatment, and who seek to die through withdrawal of that treatment:[4] For them the State simply does not inquire into intent. In this terminal-illness context, the applicability of the "assisted suicide" law is conclusively reasoned away by the legal fiction that one who "ch[ooses] . . . a natural death," Cert. Pet. 9, through the withdrawal of life-sustaining treatment simply does not have the "intent to die." As petitioners concede before this Court, although the provision of life-ending medication is flatly forbidden to a suffering, terminally ill patient whose intent is to cause death, "terminally ill people may request the withdrawal of life-sustaining treatment," *even to end their lives*, in circumstances where, but for their incurable illness, the State would treat the request as a plea for assistance in committing suicide. Pet. Br. 3; Cert. Pet. 9. See, *e.g.*, *In the Matter of Lydia Hall Hospital*, 455 N.Y.S.2d 706, 709, 711 (Sup. Ct. Nassau County 1982) (competent "terminal[ly] il[l]" diabetic who "said he was suffering so much, he wanted to die" may terminate life-sustaining dialysis).

In sharp contrast, New York applies the *opposite* presumption (namely, of "suicidal" intent) for those terminal patients who would end their suffering through the self-administration of life-ending medication. Pet. Br. 15. But, as petitioners acknowledge, a physician may lawfully assist a terminally ill patient to end life through withdrawal of life-sustaining treatment even when that patient has *precisely the same intent* as the patient-plaintiffs here who seek a physician's prescription for life-ending medication. See Pet. Br. 15-16 (arguing only that the "purpose" of one who lawfully "terminates treatment . . . *may* . . . not [be] death"); see also *In the Matter of Lydia Hall Hospital*, 455 N.Y.S.2d at 709, 711.

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[4] This description covers those who are terminally ill as well as those who suffer from conditions that drastically degrade life and that will not be cured or improved by the life-sustaining treatment. See, *e.g.*, *Delio* 516 N.Y.S.2d at 683 (right to withdrawal of food and water upheld for patient in persistent vegetative state who can breathe on his own and would, if given nutrition and hydration, remain alive indefinitely).

The purpose of the intentionally life-ending procedure is, in both cases, to "reliev[e] the patient's pain and suffering." Pet. Br. in CA2 at 27 (describing the supposed intent behind lawful withdrawal of life-sustaining treatment). And the patient-plaintiffs in this case — in precisely the same sense as those terminal patients on life-support who request the withdrawal of life-sustaining treatment — "fervently wish to live," Pet. Br. 16 (internal quotation marks and citation omitted). See, *e.g.*, JA 107 (declaration of Jane Doe) ("I have pursued medical treatment since the time my cancer was originally diagnosed to the present time."); JA 98 (declaration of William Barth) ("Since I was diagnosed HIV-positive I have received medical treatment. I believe that I have received good treatment and have benefitted from it."). Indeed, any suggestion to the contrary is profoundly offensive.

Thus, as the Second Circuit observed, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths." Pet. App. 24a. In cases in which withdrawal of life-sustaining respiration, food or water is involved, the "New York Court of Appeals" has "recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so." See Pet. App. 25a. Cf. *e.g. Eichner* v. *Dillon*, 426 N.Y.S.2d 517, 537, 539 (App. Div. 1980), aff'd with modifications, 420 N.E.2d 64 (N.Y.), cert. denied, 454 U.S. 858 (1981) (the "State['s] . . . interest in discouraging irrational and wanton acts of self-destruction" is not implicated when "the terminally ill but competent individual . . . chooses not to resist death and to die with dignity"). But "those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." Pet. App. 30a.[5]

Under New York law, the intentionally life-ending acts of those terminally ill patients who do not depend on life-sustaining treatment

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[5] Petitioners have not challenged the Second Circuit's construction of New York law. This Court in any event ordinarily defers to the lower federal courts' interpretations of state law — unless they amount to "plain" error — because the lower courts are "better schooled in and more able to interpret the laws of their respective States." *Brockett* v. *Spokane Arcades, Inc.*, 472 U.S. 491, 499-500 & n. 9 (1985).

are *deemed* "assisted suicide" by the State; the intentionally life-ending acts of those terminally ill patients who *do* depend on such treatment could also be so deemed, but they never are.

Petitioners argue that the "right of a competent adult patient to decline medical treatment . . . cannot be characterized as one to 'hasten death.'" Reply to Cert. Opp. 3. But the government's "characterization" of its actions cannot control "for constitutional purposes." *Colorado Republican Campaign Committee* v. *FEC*, 116 S.Ct. 2309, 2319 (1996) (Breyer, J., joined by O'Connor and Souter, JJ.). What matters is that, at least for the terminally ill patient in the process of dying, New York permits active physician assistance in deliberately bringing about death by the withdrawal of life-sustaining treatment — a withdrawal that, if undertaken without consent, would amount to homicide, and that, if undertaken deliberately to assist the death of an individual being treated for a condition from which recovery was expected, could be subject to prosecution for criminal assistance of suicide.

Patient-plaintiff Jane Doe, like some other terminal patients in the final stages of their illness, thus had lawfully available to her one method of physician assistance in ending her suffering. Because she required a feeding tube for nutrition and had had one surgically inserted, she could have asked to have it removed without running afoul of New York's assisted suicide laws.

But while this would have permitted Jane Doe to die with her physician's assistance before her cancer ravaged her further, she would have been subject to what for her would have been the degrading process of death by starvation. See JA 86 (Grossman Dec.) (describing "starvation and dehydration" as "an excruciating process that may continue for weeks"). She (and her family) would have been relegated to watching — perhaps only in glimpses as she was roused from a stupor brought on by malnutrition or medication or both — the degeneration of her body unto death.

For those who have a respirator removed, the state-approved process of dying is even more terrifying than it would have been for Jane Doe. "Since dying of respiratory failure can be one of the most excruciating and frightening deaths possible," JA 117 (Quill Supp. Dec.), doctors provide morphine or barbiturates to ease panic, air hunger, and the sense of suffocation, leaving patients — sometimes for weeks — in a "twilight state . . . before eventually dying." *Id.*

The administration of such drugs is lawful, even though it is undisputed that they can hasten death. *Id.* This is permitted in New York because of the familiar (but loosely applied) "double effect" principle, which applies to all patients, whether or not they are on life-sustaining treatment.

Petitioners concede that under this principle doctors may administer drugs with the "intent . . . to relieve pain and suffering" even with the foreseeable effect — indeed, the overwhelming likelihood — of causing death. See Pet. Br. 15-16 n. 9. But they may not provide medication at the request of the patient for the *purpose* of hastening death, even to end suffering in the final stages of terminal illness. See Pet. Br. in CA2 at 27.

Double effect, by relying on the fiction that the clearly foreseeable consequences of an act are not intended, often permits doctors deliberately to cause death, but because the provision of drugs for the same purpose remains criminal in all circumstances, the law prevents open consultation with the patient, the family and other physicians. Frighteningly, in these circumstances — unlike a legal regime in which open consultation about life-ending medication is permitted — "[j]ustification by double effect . . . may function as a 'fig leaf' for euthanasia." Truog, Berde, Mitchell and Grier, *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678, 1680 (1992) ("Truog, *et al.*").

Finally, even those who are *not* connected to any sort of life-sustaining device are permitted, within the lines drawn by New York law, to obtain active physician assistance in ending their lives — so long as they employ another particularly gruesome method: "terminal sedation." See, *e.g.*, Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Arch. Intern. Med. 1785, 1785-1786 (1996); see Pet. Br. in CA2 at 27.

"As the end of life approaches, th[e] relief of physical and psychological symptoms can become more difficult." Cherny & Portenoy, 10 J. Palliative Care at 31. Terminal sedation is sometimes "prescribed" for those whose misery is too great, either because of the "twisting and racking pain that invades, dominates and shrivels their consciousness, that leaves them no psychic or mental space for the things they want to think and say and do before they die," Roy, *Need They Sleep Before They Die?*, 6 J. Palliative Care 3 (1990), or because of "suffering related to existential or

spiritual concerns" that "cannot be adequately controlled despite aggressive efforts to identify a tolerable therapy." Cherny & Portenoy at 31.

Using heavy sedation or anesthesia, the doctor places the patient in "a sleep-like state" for "the last days or weeks of life." American Medical Association, *et al.* ("AMA") Br. in *Glucksberg* 6. Two authors from New York's Memorial Sloan Kettering Cancer Center describe the effect as "[t]he loss of interactional function." Cherny & Portenoy, 10 J. Palliative Care at 31. This type of "sedation" is also referred to by medical professionals as a "barbiturate coma." Truog, et al. at 1679.

Once a patient is in that deathlike state, which the doctor may maintain by a continuous infusion of barbiturates, benzodiazepines or other anesthetics at doses that will keep him unconscious, see *id.*, the patient is entitled under state law to fulfillment of his previously expressed desire to refuse "artificial nutrition and hydration." American Geriatrics Society ("AGS") Br. 7 (footnote omitted). Since with "sedation and withdrawal of treatment," AMA Br. in *Glucksberg* 10, the patient's IV tube will be delivering only unconsciousness and no food or water, the patient's body tissues and vital organs deteriorate, causing death within seven to ten days. JA 117 (Quill Supp. Dec.).

It is clear that under New York law the terminal sedation option is available to all who are terminally ill and who find their situation intolerable.[6] Indeed, it has been estimated that between 5% and 52% of dying patients "develo[p] intolerable symptoms that requir[e] terminal sedation for terminal relief." Rousseau, 156 Arch. Intern. Med. at 1785. "[S]edation can always eliminate symptoms in persons near death. This course is available at present, without any change in the law . . . ." AGS Br. 25; see also New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40, 92-94, 164 (1994) ("New York Task Force Report").

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[6] See N.Y. Penal Law §120.05(5) (otherwise applicable criminal assault statute does not apply when one "intentionally causes stupor [or] unconsciousness" if this condition is induced with "consent" or for a "medical or therapeutic treatment").

Of course, as even the AGS acknowledges in a remarkable understatement, "some may view such treatment as undesirable." AGS Br. 25; see also New York Task Force Report at 93-94 & n. 60. Indeed. Some may think it monstrous to have their minds chemically shut down and to be imprisoned in their decaying bodies and deliberately starved to death, while loved ones keep a gruesome vigil. Even aside from the fact that patients put to sleep in this way may still perceive their surroundings and feel great pain, Resp. Br. in *Glucksberg* 22 n. 13, some patients may deem the whole procedure an assault on their humanity and the very essence of degradation.

To the patients who regard this permitted last resort as horrifying, the only reply given by petitioners and their *amici* is that the "social cost of accommodating their preference for physician-assisted suicide over sedation and withdrawal of treatment is likely to be high." AMA Br. 10.

3. The Proceedings Below

The District Court granted summary judgment for petitioners. Pet. App. 63a. The Second Circuit reversed. Pet. App. 1a. Contrary to the conclusion of the Ninth Circuit in *Compassion in Dying* v. *Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), cert. granted *sub nom. Washington* v. *Glucksberg*, No. 96-110, the Second Circuit held that, "in the absence of a clear direction" from this Court, it could not recognize a constitutionally protected liberty in this case. Pet. App. 16a-20a. The court, however, struck down on equal protection grounds the ban on physician provision of life-ending medication, concluding that

> New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs.

Pet. App. 29a-30a. The court held that

> to the extent [the statutes] prohibit a physician from prescribing

medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness they are not rationally related to any legitimate state interest.

Pet. App. 35a.

Judge Calabresi concurred in the result. He concluded that "for many, many years" the State legislature "has not taken any recognizably affirmative step reaffirming the prohibition of what [plaintiffs] seek." Pet. App. 44a. Consequently, "on the current legislative record" he found a violation of both due process and equal protection. Pet. App. 62a. He would, however, have left open the possibility of reconsideration of the constitutional question "were New York to reenact [the prohibitions] while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves." Pet. App. 62a.

SUMMARY OF ARGUMENT

I. Under the procedure for defining the scope of Fourteenth Amendment Liberty described by the controlling opinion in *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), the liberty at issue in this case deserves constitutional protection. It implicates a constellation of interests each of great constitutional moment; these interests have played animating roles in this Court's previous Liberty Clause decisions. Indeed, if *Casey* is to remain defensible as a principled explication of protected liberty, the protected nature of the patient's decision at issue here must be recognized.[7]

II. The legal regime at issue in this case unduly burdens that constitutionally protected liberty. Not only does it present a virtually

[7] Petitioners have framed the Questions Presented in this case to address only equal protection principles. As prevailing parties in the Court of Appeals, respondents are of course entitled to "defend [their] judgment on any ground properly raised below." *Washington* v. *Yakima Indian Nation*, 439 U.S. 463, 476 n. 20 (1979). Consequently, and in the hope that our analysis of this question will be useful to the Court, respondents also urge affirmance of the judgment below on Liberty Clause grounds. Respondents have "pressed this issue throughout the litigation," *id.*, and "presented [it] as a basis upon which the judgment below should be sustained." *Id.* See Cert. Opp. 22 n. 8.

insurmountable obstacle to the exercise of protected liberty, it is not a reasonably tailored means of advancing any of the State's important interests in this area.

III. The legal regime here also violates equal protection. Neither the distinction between those who are on life-support and those who are not, nor the distinction between legally permitted and forbidden methods of physician assistance in dying, can survive even rational-basis scrutiny.

ARGUMENT

I. THE FOURTEENTH AMENDMENT PROTECTS THE LIBERTY AT ISSUE IN THIS CASE

This Court has held that the Constitution protects from governmental intrusion an individual's right to make certain profound, life-shaping decisions. Those decisions that "involv[e] the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 851 (1992). The final, life-shaping choices which a dying person is capable of making — so that, to the degree medically possible, the person's dying will be free of unbearable pain and suffering and will not destroy the dignity and integrity of that person as a human being — are solidly encompassed within that liberty. Indeed, if *Casey* and this Court's other holdings construing "the substantive sphere of liberty which the Fourteenth Amendment protects," *Casey*, 505 U.S. at 848, are to be understood as principled decisions, the Court must recognize the protected nature of this profoundly personal dimension of liberty.

Petitioners and their *amici* argue that recognition of the right asserted in this case will lead inevitably to recognition of a general right to die, a broad right to choose the timing and manner of one's death, or a right to physician-assisted suicide. But respondents do not urge recognition of any such broadly-defined liberty. The right asserted here is distinguishable in principle from those which concern petitioners. A patient who is in the final stages of terminal illness and who seeks to avoid a death marked by intolerable pain and suffering faces unique circumstances. The choice of how to die

is the only choice left to him. An individual whose only options are those visible from a misery-drenched deathbed has no freedom left, no control over his life at all, if the management of this choice — meager though it may seem to the healthy — is deemed to be within the plenary control of government.

For such a person, the ability to make that choice in the context of the doctor-patient relationship that has brought him this far is surely "the matrix, the indispensable condition," *Palko* v. *Connecticut*, 302 U.S. 319, 327 (1937), of any other freedom. For no other freedom is possible for a dying person — nothing remains that the dying person can call his own — if the State may prescribe the conditions under which, and the ways in which, the person may die. No liberty would truly belong to the dying individual if the process of dying were deemed a dance the State is free to choreograph, a final chapter the State is free to script.

All other persons, even the chronically ill and those who are not in the final stages of dying, may yet make many choices, select life paths, and explore possibilities that are beyond the State's authority and ability to control. Thwarted by the State in an attempt to commit suicide, they may yet live to rejoice that no "right to die" had been accorded them. A law preventing suicide in such cases cannot be said to reduce those denied such an option to "creature[s] of the state," *Pierce* v. *Society of Sisters*, 268 U.S. 510, 535 (1925), with every other liberty, and the very possibility of control over their lives, thereafter dependent on the State's sufferance.

Those who are suffering as they are about to die must be permitted this choice, not because their lives are worth less, Pet. Br. 20 & n. 10, but because — for their dignity, for their very humanity — the decision implies so much more. Indeed, respect for the precious quality of every human being requires that the Constitution be construed to protect the essential dignity of those for whom life is all but over equally with that of those with many years ahead.

This Court has already recognized just such a distinction in *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U.S. 261 (1990), in considering the withdrawal of life-sustaining food and water. It is clear that the constitutional liberty recognized in that case extends *only* to "[a] seriously ill or dying" person. *Id.* at 288 (O'Connor, J., concurring); accord *id.* at 265 (opinion of the Court) (Nancy Cruzan

had "virtually no chance of recovering her cognitive faculties"). For at the same time that this Court recognized that the liberty of someone in Nancy Cruzan's condition includes the liberty to refuse life-sustaining food and water, see *supra* p. 2, the Court also made clear that the State is not "required to remain neutral in the face of an informed and voluntary decision *by a physically able* adult to starve to death." 497 U.S. at 280 (emphasis added).

That distinction is the very one we seek to reaffirm here — between what has traditionally been deemed "suicide" and a difficult, profoundly personal decision being made by a person who recognizes, no matter how much she desires to live, that all she has before her is the question of how to die.[8]

Because this Court has observed that "[s]ubstantive due process analysis must begin with a careful description of the asserted right," *Reno* v. *Flores*, 507 U.S. 292, 302 (1993) (internal quotation marks omitted), it is vital to stress that the only right asserted by the patient-plaintiffs and claimed before this Court is the right of the competent, terminally ill patient to choose whether to endure a death marked by intolerable agony, degradation, and suffering.[9]

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[8] As the Second Circuit suggested, see Pet. App. 34a, it will be for each State — and not this Court — at least in the first instance, to decide precisely when it regards this terminal phase of the dying process to have begun. As the Second Circuit found, the problem of definition, see Pet. Br. 21, is largely imaginary, because "most physicians would agree on the definition of 'terminally ill' . . . for purposes of the relief that plaintiffs seek." Pet. App. 34a; see *id.* ("it seems even more certain" that physicians "would agree on when" the "final stages" of dying begin); see Resp. Br. in *Glucksberg* 34-35. Further, the issue is one that New York law already faces: "Physicians are accustomed to advising patients and their families in this regard and frequently do so when decisions are to be made regarding the furnishing or withdrawal of life-support systems." Pet. App. 34a; see also N.Y. Public Health Law § 2961 (defining "terminal condition" for purposes of identifying the class of patients for whom surrogates may issue orders not to resuscitate).

[9] This is the appropriate level of generality at which the liberty in question should be described. As this Court has repeatedly held, "the liberty which encompasses [the Court's previous] decisions 'includes "the interest in independence in making certain kinds of important *decisions*."'" *Casey*, 505 U.S. at 859 (citations omitted and emphasis added). Thus, unlike petitioners themselves, the United States analyzes the respondents' claim at this level of generality (although in slightly different words), concluding that indeed there

A. This Court has Articulated a Principled Approach for Defining the Liberty Protected Under the Fourteenth Amendment

Casey includes a clear and principled articulation of the proper judicial approach to determining whether a government regulation implicates a constitutionally protected liberty. The Court explained that the judicial responsibility "to define the liberty of all," 505 U.S. at 850, calls upon the Court "not to mandate our own moral code," *id.*, but "to exercise that same capacity which by tradition courts always have exercised: reasoned judgment." *Id.* at 849. See also *Rochin* v. *California*, 342 U.S. 165, 171-172 (1952) (per Frankfurter, J.).

The Court adopted the approach advanced by the second Justice Harlan, under which the Court must define the scope of liberty by reference to the historically enduring principles (and not just the concrete historical practices) that are revealed in the decisions of this Court and the traditions of this Nation.

> [T]he full scope of the liberty guaranteed by the Due Process Clause . . . . is not a series of isolated points . . . . It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . . The best that can be said is that through the course of this Court's decisions [due process] has represented the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society. . . . The balance of which I speak is the balance struck by this country, having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing. A decision of this Court which radically departs from it could not long survive, while a decision which builds on what has survived is likely to be sound.

Casey, 505 U.S. at 848-850 (quoting *Poe* v. *Ullman*, 367 U.S. 497, 543, 542 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds)); see also *Griswold* v. *Connecticut*, 381 U.S. 479, 493-498 (1965) (Goldberg, J., concurring).

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is a protected liberty at stake here. See Govt. Br. in *Glucksberg* 12.

In upholding the woman's claim of liberty in *Casey*, the Court stated that "[i]t is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity." 505 U.S. at 849 (citations omitted). After canvassing the precedents concerning marriage, procreation, contraception, the decision whether to bear or beget a child, family life and relationships, child rearing, and education, the Court concluded that such

> matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id. at 851.

The decision to end a pregnancy, the Court concluded, "originate[s] within the zone of conscience and belief." *Id.* at 852. Nonetheless, because the act of abortion is "fraught with consequences," *id.*, the Court inquired further into the nature of the liberty that the petitioners in that case sought to vindicate. The Court concluded that

> the liberty of the woman is at stake in a sense unique to the human condition . . . . The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear . . . . Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.

Id. Consequently, the Court concluded in light of "the reasoning and the tradition of the precedents we have discussed" that the liberty of

the woman to choose to end a pregnancy was constitutionally protected. *Id.* at 853. This aspect of the *Casey* decision was not, as some have suggested, grounded upon *stare decisis*. "Even on the assumption that the central holding of *Roe* was in error, that error would go only to the strength of the state interest in fetal protection, not to the recognition afforded by the Constitution to the woman's liberty." *Id.* at 858; accord *id.* at 871.

B. A Principled Interpretation of the Constitution Requires Protection of the Liberty At Issue in This Case

The words from *Casey* about the profound, personal, even spiritual significance of the constitutionally protected decision at issue there apply with at least equal strength to dying people who must decide whether to endure a death marked by intolerable suffering. This Court has already concluded that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." *Cruzan*, 497 U.S. at 281. Involving as it does profound questions of conscience and self-definition, the decision the patient-plaintiffs seek to make is unquestionably among "the most intimate and personal choices a person may make in a lifetime, [a] choic[e] central to dignity and autonomy." *Casey*, 505 U.S. at 851.

The right not to be forced to die in unendurable suffering and agony involves a constellation of interests — interests that have been recognized in this Court's previous cases — each one of which is, in and of itself, among the most profound that may be held by a human being and each of which is of constitutional dimension. To hold that the decision at issue in this case is less significant, or less firmly grounded in the Liberty Clause, than the decision whether to bear or beget a child, or to use contraceptives, or to send one's child to private school, would do irreparable damage to this Court's commitment to principled exposition of constitutional rights.[10]

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[10] Indeed, it would render this Court's decision in *Casey* itself vulnerable to repudiation as unprincipled and *ad hoc*, an illegitimate interference with the power of the State. Remarkably, some *amici* before this Court already argue that this Court should reverse in this case to make clear that *Casey* cannot "serve as . . . a precedent." See Br. of Sen. Orrin Hatch, *et al.* 22 (argument heading).

1. To begin with, of course, there is the interest in bodily integrity. Justice Cardozo's classic formulation comes from a New York State case: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . ." *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y. 1914). "It is settled now . . . that the Constitution places limits on a State's right to interfere with a person's most basic decisions about . . . bodily integrity." *Casey*, 505 U.S. at 849. See, *e.g.*, *Washington* v. *Harper*, 494 U.S. 210, 221-222 (1990); *Rochin* v. *California*, 342 U.S. 165, 172 (1952); *Cruzan* 497 U.S. at 288 (O'Connor, J., concurring).

This Court's cases make plain that this interest is not confined to avoiding forcible bodily intrusion but is equally implicated by a rule — such as that at issue in this case — prohibiting desired medical intervention. Indeed, as Justices O'Connor, Kennedy and Souter concluded in their opinion for the Court in *Casey*, the constitutional protection of the liberty of a woman seeking a doctor's assistance in terminating the natural progress of her pregnancy is, among other things, "a rule . . . of personal autonomy and bodily integrity." *Casey*, 505 U.S. at 857 (citing *inter alia Cruzan*, 497 U.S. at 278). Thus, this Court stuck down in that case a husband notification provision that might have prevented a woman from ending her pregnancy in part because "the State has touched not only upon the private sphere of the family but upon the very bodily integrity of the pregnant woman. Cf. *Cruzan* v. *Director, Mo. Dept. of Health*, 497 U.S. at 281." *Casey*, 505 U.S. at 896. Indeed, the very liberty to obtain medical treatment — a liberty surely protected under the Fourteenth Amendment, see Govt. Br. in *Glucksberg* 13 — implicates the interest in bodily integrity without involving any forcible bodily intrusion.

2. Next, the deeply personal interest in freedom from pain and suffering, even apart from the interest in personal autonomy, is implicated here as well. This, too, is unquestionably of constitutional dimension. In *Casey* this Court rested its conclusion about the woman's liberty partly on this very aspect of pregnancy: "The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. . . . Her suffering is too intimate and personal," 505 U.S. at 852, for "the State to insist she make the sacrifice." *Id.*

One need not denigrate the pain and physical difficulty associated with childbirth or, indeed, the psychological pain and anguish associated with continuing an unwanted pregnancy, cf. Govt. Br. in *Glucksberg* 14, to recognize that the profound and unendurable suffering alleged by the plaintiffs here is no less than that associated with unwanted pregnancy, and that for the patients who seek the aid of this Court, it is all the more profound because it will last, without respite, until the short time left in their lives is over.[11]

3. Finally, the decision of one who is dying whether to endure an excruciating death involves, no less than the abortion decision, "the right to define one's own concept of existence, of meaning, of the universe, and" — most profoundly — "of the mystery of human life." 505 U.S. at 851. A decision about whether to die in such a way, or instead to take some action to hasten the end of suffering — be it withdrawal of food, or self-administration of some life-ending drug — is inevitably a reflection of a person's understanding of the meaning of life and of the role of death in that life. Undoubtedly it is true that "many religious and philosophical traditions hold that this suffering may be of great value." Truog, *et al.*, 327 New Eng. J. Med. at 1680. But "[b]eliefs about th[is] matter could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 505 U.S. at 851. This decision, like the decision whether or not to choose abortion, must "originate within the zone of conscience and belief." *Id.* at 852. It involves "[t]he destiny" of the patient, which "must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society." *Id.* Although, again as with abortion, the decision not to endure that suffering may be viewed by "some [as] nothing short of an act of violence against . . . human

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[11] Cf. Govt. Br. in *Glucksberg* 14-15 (arguing unconvincingly that the interest of a terminally ill patient in avoiding severe suffering is not as consequential as the interest in terminating a pregnancy). Nor need one denigrate the profound implications of the abortion right for women's equality — implications recognized in *Casey*, 505 U.S. at 856 — to recognize that, at least until now, laws prohibiting abortion have been invalidated by this Court only on Liberty Clause grounds, and that their invalidation on those grounds is appropriate. See Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe *v.* Wade, 63 N.C. L. Rev. 375, 382 (1985).

life," and although that pain might be "endured . . . with a pride that ennobles" the sufferer in the eyes of some, such "suffering is too intimate and personal for the State to insist, without more," *id.*, that an individual *must* bear it.

4. It is not our contention, as some of petitioners' *amici* suggest, that *Casey* has removed history and tradition from the due process equation. As the language from Justice Harlan quoted in *Casey* makes clear, 505 U.S. at 848-850, tradition is an important guidepost for judges bound to define the scope of the Liberty Clause of the Fourteenth Amendment. *Casey* recognized that constitutional significance inheres, however, not in the historic legality or illegality of a specific act, but in the treatment, in our history and tradition, of interests like those in bodily integrity and autonomy, in avoiding pain and suffering, and in making profoundly intimate and personal life-shaping decisions.

Concluding that the alternative would amount to nothing less than "shrink[ing] from the duties of our office," *id.* at 849, this Court, in "interpreting the full meaning" of the Constitution "in light of all our precedents," *id.* at 901, in *Casey* resoundingly rejected the view

> that the Due Process Clause protects only those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified.

Id. at 847 (citing *Michael H.* v. *Gerald D.*, 491 U.S. 110, 127-128 n. 6 (1989) (opinion of Scalia, J.)).

The Court observed that in many prior cases it had found practices protected under the Liberty Clause despite their having been unlawful in many states at the time of the ratification of the Fourteenth Amendment. *Id.* at 847-848. To the list given there can be added the right of a patient like Nancy Cruzan to refuse life-sustaining food and water. Thus, the fact that most states historically have forbidden physicians to provide life-ending medication to their suffering patients in the final stages of terminal illness does not alter the constitutional calculus in this case. Cf., *e.g.*, *Loving* v. *Virginia*, 388 U.S. 1, 12 (1967).

The protection of interests like bodily integrity and autonomy reflects "respect for the teachings of history . . . [and] the basic values that underlie our society." *Griswold*, 381 U.S. at 501

(Harlan, J., concurring). The Liberty Clause protects decisions where the underlying values at stake — not the particular practice at issue — are "deeply rooted in this Nation's history and tradition." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (plurality opinion of Powell, J.).

The Court in *Casey*, then, consistent with precedent, examined the "basic reasons why certain [actions] . . . have been accorded shelter under the Fourteenth Amendment," *id.* at 501, and concluded that those reasons required recognition of the liberty of a woman to choose whether or not to end a pregnancy. Those same reasons require recognition of the liberty asserted here.[12]

C. The *Cruzan* Decision, Too, Compels Recognition of the Patients' Fourteenth Amendment Liberty

The *Cruzan* Court's conclusion that Nancy Cruzan's constitutionally protected liberty to refuse "medical treatment" included the right to refuse artificial delivery of food and water, see *supra* p. 2, also requires recognition of the liberty at issue here.

1. In *Cruzan* this Court recognized that the right to refuse "medical treatment" included the right to refuse artificial delivery of food and water, "[w]hether or not the techniques used to pass food and water into the patient's alimentary tract are termed 'medical

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[12] The values at stake here are reflected in the sanctity with which the deathbed has always been surrounded in our history and tradition. An enormous solicitude for the rights of individuals as their lives draw to a close has marked our culture. Both the words and the wishes of one on his deathbed have traditionally and deservedly received legal protection. Thus, deathbed statements are generally admissible as evidence despite the hearsay rule, and the wishes of one facing imminent death are honored even when otherwise-required legal formalities are not met. See, *e.g.*, *Ridden v. Thrall*, 26 N.E. 627, 629 (N.Y. 1891) (gifts *causa mortis*). Even as death has, for most of us, changed its venue from the home to the hospital, there has been no concomitant change in our firmly-rooted tradition that holds death to be a personal and intimate event or in our belief that, to the extent possible, the dying person should be able to obtain that which will bring comfort. The very manner of dying — whether in solitude or surrounded by loved ones, with which family members to share one's final days and hours, from whom to seek solace and spiritual assistance — has always been recognized as a matter of profoundly personal choice.

treatment,'" 497 U.S. at 288 (O'Connor, J., concurring). This recognition undoubtedly was influenced by the profound indignity that would be wrought upon an unconscious patient by the slow atrophy and disintegration of her body that would accompany her continued life or what might more properly be called her "prolonged death." Cf. App. to Pet. for Cert. at A96, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990) (No. 88-1503).

The importance to this case of *Cruzan*'s extension of the right to refuse medical treatment to include decisions to forego food and water cannot be overstated. The recognition of that right can only be understood as a recognition of the liberty, at least in some circumstances, to physician assistance in ending one's life. That was the very point of the Court's statement that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." *Id.* at 281 (opinion of the Court).

Cruzan by its terms of course dealt with a physician's assistance in withdrawing nutrition and hydration, not with the provision of a life-ending prescription. But that cannot affect the nature of the *liberty* involved. Most important in *Casey* was this Court's recognition that the character and strength of an asserted liberty is the same whether the decision ultimately requires the state to respect the patient's wish to be free of medical intervention (as when a woman seeks to avoid a governmentally *coerced* abortion) or to respect the patient's wish to seek a physician's assistance in provision of a medical procedure (as when a woman seeks invalidation of a governmental *ban* on abortions). That was the point of the statement by Justices O'Connor, Kennedy and Souter, writing for the Court, that

> The soundness of [the liberty] prong of the *Roe* analysis is apparent from a consideration of the alternative. If indeed the woman's interest in deciding whether to bear or beget a child had not been recognized as in *Roe*, the State might as readily restrict a woman's right to choose to carry a pregnancy to term as to terminate it, to further asserted state interests in population control, or eugenics, for example. Yet *Roe* has been sensibly relied upon to counter any such suggestions.

Casey, 505 U.S. at 859 (citing cases involving forced abortion, coerced sterilization and the right to refuse life-sustaining treatment).

This quoted language from *Casey* also recognizes that the liberty to make protected decisions is a two-way street, so that it is inherent in a claim to such autonomy that a court cannot ask which way it will be exercised before concluding that liberty is indeed at stake. The *interests* asserted to overcome a claim of liberty will differ depending upon whether the State desires to prohibit its exercise in one or another direction (e.g., the interest in life vs. the interest in population control). And those interests may be of different strength, so that in theory one option might be permissible while another one is not. But those interests must be weighed against the protected liberty; they are not to be front-loaded into its definition.

Given this understanding of liberty, if the patient-plaintiffs here were to have no liberty to shorten their suffering, they would have no liberty to prolong it either. In an age of managed care, one can readily imagine a State deciding to prohibit extraordinary treatment for suffering patients who are about to die, on the ground that scarce resources would best be allocated elsewhere. See Pet. Br. 26 n. 15.

2. Further, this Court should recognize that advances in medical technology have all but swept away any line that once existed between the "artificial" life support that imprisoned Nancy Cruzan and the so-called "nature" that imprisons the patient-plaintiffs here. As Justice O'Connor put it in her opinion in *Cruzan*, "[a] seriously ill or dying patient whose wishes are not honored may feel a captive . . . . " *Id.* at 288 (O'Connor, J., concurring). Although the captivity she described there was the captivity "of the machinery required for life-sustaining measures or other medical interventions," *id.*, the idea of "captivity" applies with equal strength to those whose suffering takes place in lives not only prolonged but profoundly transformed — as so many now are (and as those of the named patient-plaintiffs here were) — by heroic or recently-unimaginable medical advances.

One may be alive only as a result of chemotherapy, antibiotics, bone-marrow transplants or any of the other wide range of life-prolonging therapies — each of which changes the patient unalterably, and ultimately may leave her "suffering" a "prolonged deat[h]" quite different from what "nature" would otherwise have decreed. See, *e.g.*, JA 126 (Declaration of Jack Froom, M.D.). When one then confronts, precisely because of that treatment, an end filled with life-encompassing pain, disintegration or suffering, how

can one *not* "feel a captive," *Cruzan*, 497 U.S. at 288 (O'Connor, J., concurring), to the very technology that has brought one to that point? To give but one of myriad examples, a patient who receives a bone marrow transplant may live longer than he otherwise would, but the very life-saving transplant may subsequently produce "graft versus host" disease in which the bone marrow graft actually attacks the rest of the host body and slowly kills it. For such persons, at the very least, there can be no doubt but that their liberty to choose death must be as great as Nancy Cruzan's.

3. There are also those terminally ill patients who receive ongoing palliative treatment that is itself profoundly painful, but without which their lives would be even more harrowing. Such treatments include, for example, daily infusion therapies, debriding dressing changes so painful they may require premedication with narcotics, and suction catheterization of the trachea to remove secretions. Ending such palliative — yet not life-sustaining — treatments would be unthinkable for these patients. They are thus left "captive of . . . medical interventions" just as Nancy Cruzan was, with "[s]uch forced treatment burdening [their] . . . liberty interests as much as any state coercion." *Id.*

4. The development of increasingly sophisticated life-prolonging techniques animates the entire question in the modern world of physician assistance in dying. See Preston, *Physician Involvement in Life-Ending Practices*, 18 Seattle L. Rev. 531, 542 (1995) ("Today, whether by intravenous feeding or by multiple-organ transplants, ... [m]ost persons in the late stages of dying are in their particular conditions exactly because of [past] medical intervention[s]."); Benrubi, *Euthanasia — The Need for Procedural Safeguards*, 326 New Eng. J. Med. 197-199 (1992) (describing life-prolonging treatments that result in prolonged suffering, and deaths "more protracted and uncomfortable" than the patient, even though not "on" life support, would have had otherwise). Changes in technology are likely to make whatever remains of the "natural"/"artificial" distinction grow even less meaningful in the future. This case thus requires the Court to apply the same principles that underlie *Cruzan* to factual circumstances vastly changed even from the time of the adoption of the very laws at issue in this case. Cf. *Ollman* v. *Evans*, 750 F.2d 970, 995 (D.C. Cir 1984) (en banc), cert. denied, 471 U.S. 1127 (1985) (Bork, J., joined by Wilkey, Ginsburg and MacKinnon, JJ., concurring) ("Where there

is a known principle to be explicated the evolution of doctrine is inevitable . . . In a case like this, it is the task of the judge in this generation to discern how the framers' values, defined in the context of the world they knew, apply to the world we know.").

Due Process would not, in the 18th through mid-19th centuries, likely have been thought to include the right to avoid the artificial prolongation of life. But medical science was primitive. Cf. Maurice B. Gordon, *Aesculapius Comes to the Colonies* 5 (1949). It has been only this century that ushered in the life-extending medical techniques that may, for all their benefit, also lead to more grotesque forms of death, and with them the recognition of the constitutional significance of avoiding an artificially-prolonged life. See *Cruzan*.

As their declarations make clear, each of the patient-plaintiffs in this case was — thankfully — kept alive by extraordinary medical advances, only to face a lingering death instead of what might have been a swift one. In defining the scope of their liberty in this case in light of that modern reality, this Court must take account of the factual circumstances in which its decision will apply. It must issue a decision that is "defensible . . . as [an] applicatio[n] of constitutional principle to facts as they ha[ve] not been seen by this Court before." *Casey*, 505 U.S. at 863-864. Indeed, a proper understanding of these "significant facts," *id.* at 866, is essential to the very performance of the judicial function in this case.

D. Recognition of the Liberty Involved Here Does Not Require Taking the Approach That Led to Much of the Criticism of *Roe* v. *Wade*

A judgment of affirmance here can and should be rendered in a way that avoids the pitfalls that led to much of the scholarly criticism of the decision in *Roe* v. *Wade*, 410 U.S. 113 (1973). *Roe* almost completely foreclosed the States from legislating in the area of abortion, in an opinion that "'rea[d] like a set of hospital rules and regulations.'" Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe *v.* Wade, 63 N.C. L. Rev. 375, 381 (1985) (brackets added) (quoting Archibald Cox, *The Role of the Supreme Court in American Government* 113 (1976)). Commentators have urged that "[t]he Court properly invalidated the

Texas proscription" at issue in *Roe* "because '[a] law that absolutely made criminal all kinds and forms of abortion . . . is not a reasonable accommodation of interests,'" *id.* at 382 (quoting Freund, *Storms Over the Supreme Court*, 69 A.B.A. J. 1474, 1480 (1983)), but that "[i]f *Roe* had left off at that point and not adopted . . . a 'medical approach,'" the decision would have been understood more widely as an appropriate judicial act. *Id.*

Because New York's criminal law is so extreme, this case presents an opportunity appropriately to vindicate individual liberty while avoiding these pitfalls. The controlling opinion in *Casey* abandoned *Roe*'s "elaborate but rigid," 505 U.S. at 872, framework in favor of the "undue burden" standard under which this Court would be able to invalidate the complete criminal prohibition at issue here while permitting a substantial degree of less intrusive regulation. This standard promises the "reasonable accommodation of interests" that critics of the *Roe* opinion have argued is appropriate.

II. ALTHOUGH THIS LIBERTY CAN BE CLOSELY REGULATED, THE STATE'S ABSOLUTE BAN IMPOSES AN UNDUE BURDEN ON ITS EXERCISE

Recognition of a protected liberty is of course only the first half of the due process equation. Before determining that a law or regulation is unconstitutional, a court must weigh the countervailing state interests urged in its support to see if they may justify the particular interference with protected liberty. See, *e.g.*, *Cruzan*, 497 U.S. at 279. The question of whether laws touching upon the liberty at stake in this case should be measured under the undue burden standard adopted by the controlling opinion in *Casey*, 505 U.S. at 876 (plurality opinion), or under the test which asks whether a regulation is "narrowly tailored to serve a compelling state interest," e.g., *Reno* v. *Flores*, 507 U.S. 292, 302 (1993), is one this Court need not resolve here, for the blanket prohibition at issue in this case cannot survive under either standard.

The United States, acknowledging the liberty at stake here, argues that the Court should apply "the same legal standard" it applied in *Cruzan*. Govt. Br. in *Glucksberg* 17. But *Cruzan* itself did not explicitly apply *any* particular standard of review, holding only that the procedural requirements put in place in that case by Missouri law

"permissibly . . . advance [the State's] interests." 497 U.S. at 282.[13] This Court, however, has subsequently made clear that *Cruzan* necessarily stands for the proposition that "a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." See *Casey*, 505 U.S. at 857 (citing *Cruzan*, 497 U.S. at 278). This is consistent with the undue burden standard articulated in *Casey*, a standard whose application suffices to support affirmance here.

Indeed, application of the undue burden standard may be particularly appropriate in this case, for it was designed to accommodate important state interests when an individual seeks to make a constitutionally protected choice, like the one involved in this case, "that has such profound and lasting meaning." *Casey*, 505 U.S. at 873 (plurality opinion).

The joint opinion in *Casey* articulated "[s]ome guiding principles" for application of the undue burden test, which it described as "a standard of general application." See 505 U.S. at 877, 876 (plurality opinion); see also *id.* at 878. Under this test, regulations touching on a protected liberty will be upheld only if they are "reasonably related," *id.*, or "'reasonably directed,'" *id.* at 900, to an "'important and legitimate,'" *id.* at 871, or "substantial," *id.* at 876, governmental interest. Further, no regulation will be permitted "that has the purpose or effect of placing a substantial obstacle in the path" of an individual seeking to exercise a constitutionally protected liberty. *Casey*, 505 U.S. at 877 (plurality opinion); see also *id.* at 878 (illustrating that even a properly tailored regulation will be struck down if it has this purpose or effect). In determining whether it poses a "substantial obstacle," a law that touches on constitutionally protected liberty is to be measured by reference to "those for whom it is an actual rather than an irrelevant restriction." See *id.* at 895;

[13] The United States describes *Cruzan* as applying "an intermediate standard . . . in which the individual's 'liberty interests' are 'balance[d] • • • against the relevant state interests.'" Govt. Br. in *Glucksberg* 17 (quoting *Cruzan*, 497 U.S. at 279). The quoted language from *Cruzan*, however, does not articulate a legal standard. An examination of the quoted passage reveals that it merely describes the process by which a court — under whatever standard — must evaluate a claim that a law or regulation unlawfully infringes upon a constitutionally protected liberty.

see also *Fargo Women's Health Organization* v. *Schafer*, 507 U.S. 1013, 1014 (1993) (O'Connor, J., joined by Souter, J., concurring in denial of application for stay and injunction).

States are permitted under the undue burden test to enact laws that "create a structural mechanism by which the State, or [an interested individual], may express profound respect for . . . life . . . , *if they are not a substantial obstacle*" to the person's "exercise of the right to choose." *Id.* at 877 (emphasis added). This may include regulations that "provide a reasonable framework" for ensuring that the liberty is not exercised incautiously, *id.* at 885-887, as well as regulations designed to persuade the individual to choose life. See *id.* at 872-873. The test recognizes that "[w]hat is at stake is the [person's] right to make the ultimate decision, not a right to be insulated from all others in doing so." *Id.* at 877.

A. The Legitimate Interests Put Forward by Petitioners Cannot Justify The Challenged Laws

None of the interests put forth by petitioners suffices to justify New York's legal regime.

1. Petitioners begin with the State's interest in protecting life in all circumstances. See Pet. Br. 20-21. Accepting that interest as legitimate, the criminal laws at issue here sweep much too broadly, placing a substantial (indeed, a virtually insurmountable) obstacle in the path of those in the final stages of terminal illness who are not on life-support and who seek to exercise their protected liberty to choose a death free of unbearable pain and suffering. See Resp. Br. in *Glucksberg* 27. Such a "plenary override of individual liberty claims" like these has been held impermissible. See *Casey*, 505 U.S. at 857 (citing *Cruzan*, 497 U.S. at 278).

The argument that the ban is essential to meet the State's interest in protecting life in all circumstances is also fatally undermined by the fact that the State has chosen to authorize much requested physician action intended to result in the death of a competent terminally ill adult. Cf. *City of Ladue* v. *Gilleo*, 114 S.Ct. 2038, 2044 (1994) (exemptions from a ban, there on displaying signs, "diminish the credibility of the government's rationale" for imposing the restriction in the first place). It permits, virtually without regulation, the life-ending withdrawal of treatment, including

nutrition and hydration, and it allows terminal sedation of those who are not already on life-support. New York's legal regime thus would not be a reasonable means of advancing the State's interest in life even if it did not present a substantial obstacle to the exercise of protected liberty. See *e.g.*, *Clark* v. *Jeter*, 486 U.S. 456, 464 (1988) (six-year statute of limitations for child support actions involving illegitimate children not "substantially related" to Pennsylvania's interest in avoiding litigation of stale or fraudulent claims because "[i]n a number of circumstances [the State] permits the issue of paternity to be litigated more than six years after the birth of an illegitimate child").

Petitioners argue that what is permitted in terms of withdrawal of life-sustaining treatment "may be distinguished" from what is forbidden "on the basis of [the] intention of both physician and patient." Pet. Br. 15. But, as we have seen, the law of New York does not actually hew to this line, instead permitting withdrawal of treatment even where the actual intention of both doctor and patient plainly is to cause death. Ultimately, petitioners acknowledge as much, arguing only that the purpose of one who seeks withdrawal of treatment "*may* be not death but, for example, the avoidance of invasive medical technology." Pet. Br. 16.

Petitioners also argue that their decision to permit withdrawal of life-sustaining treatment is justified by a difference in the cause of death: "[a] patient who declines or withdraws from life-sustaining treatment is letting nature take its course," Pet. Br. 17, whereas one who is not on artificial life support dies "from the drugs alone." *Id.* 18.[14] But even putting to one side the manifestly *un*natural case of terminal sedation, the law of New York recognizes that withdrawal of life support is ordinarily a but-for cause of the death that inevitably ensues. It punishes unconsented withdrawal of life-sustaining treatment as homicide. And even the consensual withdrawal of life-sustaining treatment for the purpose of causing the death of one who is not terminally ill may sometimes be treated as

[14] In truth, of course, since withdrawal of a life-support system such as a respirator is invariably accompanied by pain medication, "it is not possible to know if the morphine or the disease produced the actual moment of death." Br. of Choice in Dying 11.

unlawful assisted suicide. See *Fosmire* v. *Nicoleau*, 551 N.E. 2d 77, 82 & n. 2 (N.Y. 1990); *Van Holden* v. *Chapman*, 450 N.Y.S. 2d 623, 625, 626-627 (App. Div. 1982). Thus, New York law does not simply permit nature to "take its course."[15]

Finally, the AMA argues that the State must permit withdrawal of life-sustaining treatment (but not the provision of life-ending medication) because patients would be reluctant without that option to accept many modern treatment regimens. AMA Br. 23. Yet this cannot explain the line drawn by the State, because many life-prolonging treatments that do not involve permanent attachment to life-sustaining equipment — from antibiotics to chemotherapy to surgery — leave patients at a profound risk of debilitation or pain. If the option of withdrawing life-sustaining devices is necessary to encourage people to seek therapies that require such devices, then the option of life-ending medication should be equally necessary to encourage people to obtain this latter class of life-prolonging treatment.

2. Next the State and its *amici* proffer a series of interests related to the protection of those who are "outside the class of persons described by the Court of Appeals": those for whom palliative care or treatment of depression might ease suffering, those for whom exercise of the liberty might not truly be voluntary, and those who are not actually in the final stages of terminal illness. See Govt. Br. in *Glucksberg* 23. These reflect serious concerns about avoiding abuse and the mistaken exercise of this life-ending liberty. See Pet. Br. 27; Govt. Br. in *Glucksberg* 19-24 (detailing ways in which the decision to end life may be mistaken or may be the result of pressures felt from physicians and family).

Undoubtedly the protection of people who might seek to end life mistakenly or under pressure is a compelling interest. This interest, however, does not require a complete ban on the provision of life-

[15] Petitioners also argue that the interest in protecting life does not require prohibiting withdrawal of life-sustaining treatment when intended to cause death because of the "difference between action and inaction." Pet. Br. 16-17. The State's homicide laws of course answer this, recognizing that the removal of, say, a feeding tube does not amount to "passive inaction," *id.* at 17 (internal quotation marks and citations omitted). Indeed, if anything, death from a drug that is self-administered involves *less* action on the part of the physician.

ending medication even to those for whom the right to self-administer such a prescription drug is a protected liberty, and who act without pressure or error. There are a number of less restrictive mechanisms that the State could mandate that would reasonably advance — would in fact be precisely tailored to address — the interests petitioners and their *amici* put forth. See Br. of State Legislators in Support of Respondents 23-25, 29, App. 1a-12a. Indeed, in permitting the issuance of orders not to resuscitate — which implicate many of these same concerns — New York has already put some such regulations in place. See N.Y. Public Health Law § 2964.[16]

In light of such alternatives, the ban at issue in this case, even if it did not strike impermissibly to the bone of protected liberty, could not be said "reasonably" to advance the State's interest in avoiding mistake or coercion. Indeed, at least unless it is absolutely necessary, the imposition of intolerable suffering upon a human being is not a constitutionally permissible means of achieving these or the other goals put forward as justifications for the law at issue here, such as creating an incentive for improving the medical profession's attention to patients' pain, see AMA Br. 22, or "increas[ing] the public's awareness of hospice" care. National Hospice Association Br. 18. Cf. *Eisenstadt* v. *Baird*, 405 U.S. 438, 448 (1972).

Furthermore, any argument that this ban has been put in place as a necessary mechanism to prevent mistakes, coercion or, indeed, even involuntary euthanasia, dissolves in the face of the fact that some patients already intending to die may lawfully receive, essentially without any regulatory safeguards at all, physician assistance in dying through the withdrawal of life-sustaining treatment (or through the process of terminal sedation).[17] The

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[16] That *any* regulatory scheme might occasionally be evaded by the physicians subject to it, Pet. Br. 31, proves too much: the "outright prohibition" defended as an alternative to targeted safeguards, AMA Br. 23, has already proven susceptible to circumvention, and may indeed invite a cynicism that makes evasion even more tempting. See *infra* at p. 40-42.

[17] Coercion and undue influence in this setting might be addressed by the criminal prohibition against "caus[ing] . . . suicide," *e.g.*, N.Y. Penal Law § 125.15(3), which is not challenged in this action. And indeed, because that

precise risks about which the State claims to be concerned are of course equally present in those circumstances. Indeed, many of them (such as family coercion or a failure of physician sensitivity) might well be *more* salient in the case of a person connected to life-sustaining medical equipment. And, because disconnecting life-support machinery typically gives the patient no last clear chance at a change of heart — it is the doctor's hand, not the patient's, that takes the final step[18] — there is, if anything, *less* basis for confidence that the process causing the patient's death is in fact a genuine expression of the patient's free and informed will rather than the instrument of a homicide.[19]

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statutory provision could be applied to those who pressure patients to request or use life-ending medication as well, there should be no concern that affirmance in this case will create a regulatory vacuum until the state legislature can revisit the matter. Further, the laws here are challenged not on their face but only as applied to the class of terminally ill, competent persons who voluntarily choose to obtain a prescription for life-ending medication. New York's Attorney General would be free to enforce the state's assisted suicide laws with respect to all others and indeed would be free immediately to adopt interim guidelines to ensure that only competent persons in the final stages of terminal illness avail themselves of the relief sought here and that all decisions concerning life-ending medication are fully voluntary.

[18] Indeed, in one major study, 39% of the patients who asked for and received lethal medication (despite the formal illegality) did not use it once their sense of control was re-established. Back *et al.*, *Physician Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 922 (1996); see also Richard Posner, *Age and Old Age* 224 (1995) (predicting that permitting physicians to prescribe life-ending medication "might actually reduce the number of suicides and postpone the suicides that do occur").

[19] The suggestion by the United States that withdrawal of life-sustaining treatment may be distinguished from the provision of life-ending drugs on the ground that withdrawal may reveal that a person has been misdiagnosed, see Govt. Br. in *Glucksberg* 25 — something that typically would not happen with a prescription of life-ending medication — is wrong. Patients like Nancy Cruzan will invariably die quite quickly if their life-support is withdrawn, regardless of the accuracy of their physicians' diagnosis that there is no hope of recovery. (Thus, as biology dictates, Karen Ann Quinlan, who was ultimately able to breathe on her own, lived for years after withdrawal of her respirator, see Govt. Br. 14, only because artificial nutrition and hydration were provided.) That certainty of death is precisely why this Court in *Cruzan* concluded that it was permissible to place the risk of error on the party seeking

In any event, this Court has never permitted a State completely to deprive some persons of a constitutionally protected liberty in order to protect "*other* persons," Govt. Br. in *Glucksberg* 19 n. 2 (emphasis added), from its own failure to put in place mechanisms to ensure that this liberty is exercised only by those entitled to do so. See, *e.g.*, *Sable Communications* v. *FCC*, 492 U.S. 115, 128 (1989) (even to protect children, government may not "reduce the adult population . . . to . . . only what is fit for children") (ellipsis in original, internal quotation marks and citations omitted).

3. Petitioners and their *amici* also argue that the liberty at stake here is outweighed by the countervailing interest in preventing such consequences as non-voluntary euthanasia and euthanasia under a "best interests" standard for incompetent patients. Pet. Br. 23-24.

Cruzan itself provides the strongest response. The Court there held it permissible for a state to "seek to safeguard the personal element" of the "choice between life and death" "through the imposition of heightened evidentiary requirements" whenever it allows a surrogate to exercise the rights of an incompetent patient. 497 U.S. at 281; see also *id.* at 289-292 (O'Connor, J., concurring).[20]

In any event, the "slippery slope" claim here rings particularly hollow in light of the types of life-ending measures the State already permits physicians to undertake. If there is a slope to fear, the State — in permitting withdrawal of life-support, death by "double-effect" and terminal sedation, all essentially without regulation — has already slid along it further than anything respondents seek.

In particular, under the guise of "double effect," acts of euthanasia take place in New York and throughout the United States *every day*. See, e.g., Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1376 (1996). Dying

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to terminate life-support. See *Cruzan*, 497 U.S. at 283.

[20] Petitioners raise concerns about suffering, terminally-ill patients who are unable to administer drugs to themselves. Pet. Br. 23. But any competent individual, however disabled, who is able with the assistance of modern technology unambiguously to *communicate* a voluntary decision to receive life-ending medication could certainly be enabled, through modern technology, to *self-administer* it.

patients in agony, whose pain cannot be soothed with medication, are given increasingly large doses of painkillers that will undoubtedly kill them. E.g., Cotton, *Medicine's Position is Both Pivotal and Precarious in Assisted Suicide Debate*, 273 JAMA 363 (1995). But because states like New York make it hazardous for the foreseeable, natural consequence of this medication to be confronted frankly, the drugs are administered — by doctors undoubtedly acting in what they believe to be the best interests of their patients — without the full discussion of the consequences to which respect for a patient's very humanity entitles her. *Id.* ("We talk about the 'double effect,' and know jolly well we are sedating them into oblivion, providing pain relief but also providing permanent relief, and we don't tell them.") (quoting Dr. Peter Goodwin); see Br. of Coalition of Hospice Professionals for Affirmance 26.[21] In this

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[21] Petitioners' claims about the Netherlands, see Pet. Br. 24 n.13, are conspicuously bereft of any evidence at all that Holland's decision to permit physician assistance in dying (while still deeming it technically criminal) actually led to any *increase* in involuntary euthanasia by doctors rather than simply bringing to light "a practice that, in the Netherlands as in every other country (including the United States), has been going on undercover and entirely at the discretion of the physician." Margaret Battin, *The Least Worst Death* 141 (1994). The most recent report on the subject concludes that the data of the well-known 1991 study of the Dutch experience, and of its 1996 successor, "do not support the idea that physicians in the Netherlands are moving down a slippery slope" towards "less careful end-of-life decision making and . . . the gradual social acceptance of euthanasia performed for morally unacceptable reasons." van der Maas *et al.*, *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands*, 1990-1995, 335 New Eng. J. Med. 1699, 1705 (1996).

To the extent that any conclusions can be drawn, it appears that a system of genuine regulation might actually lead to a *decrease* in the rate of nonvoluntary euthanasia. Although there are no strictly comparable data, studies suggest that there may be more such euthanasia in the United States than in Holland. For example, seven percent of surveyed U.S. critical care nurses had "engag[ed] in euthanasia or assisted suicide without a request from either the patient or a surrogate." See Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1376 (1996). The article reporting that data appears to suggest that some of the patients killed in this way were mentally competent. *Id.*

The precisely comparable figures for the Netherlands are difficult to determine, since in the Dutch studies "nonvoluntary" euthanasia has been

regard, a decision of this Court upholding the right of patients to discuss and receive life-ending medication openly — a decision that will doubtless lead to regulation of these life and death decisions — may actually play a critical role in pulling this nation *back* from the precipice of involuntary euthanasia.[22]

B. The Only Rationales That Adequately Explain New York Law are Impermissible Bases for Imposing Such Suffering on the Dying Patient

Implicitly acknowledging that the State permits, in the case of withdrawal of life-sustaining treatment, precisely the acts that it would deem "assisted suicide" were they to involve the provision of life-ending prescription drugs, the United States attempts to defend the State's regime on the ground that "[i]n one case, the cause of death *can reasonably be viewed* as the underlying disease;" in the other, "the cause of death can only be *viewed* as the lethal medication." Govt. Br. in *Glucksberg* 24 (emphasis added). The United States argues that permitting the more obvious type of physician assistance "'[c]ould have a subtle but widespread impact on society' by sending the message that society does not value each of its members." Govt. Br. 12 (citation omitted). In essence,

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defined to include all deaths caused intentionally but without a "concurrent, explicit" request by the patient. But the latest Dutch report suggests that in *every* case involving a competent patient whose death was counted within this category (many of whom had only hours or days to live), "either the decision was discussed with the patient earlier in the illness or the patient had expressed a wish for euthanasia if suffering became unbearable." See van der Maas, *et al.*, 335 New Eng. J. Med. at 1701.

[22] Petitioners contend that the liberty urged here will require patients constantly to justify their decision to remain alive. Pet. Br. 32. The fatal problem with this argument is that it could be used to object to any constitutionally protected liberty, from the right to free speech to the right to choose abortion. A State's desire to protect its citizens from the "burden" of liberty is obviously illegitimate. In any event, terminally ill patients on life support already must confront this choice under New York law. As the Second Circuit found, just as much "'psychological pressure' can be applied" upon "the elderly and infirm to consent to withdrawal of life-sustaining equipment as to take drugs to hasten death. . . . [T]he state of New York may establish rules and procedures to assure that all choices are free of such pressures." Pet. App. 32a-33a.

therefore, this final argument for reversing the decision below amounts to a claim that, whatever constitutional rights dying individuals might have to avoid the agony or indignity to which some are condemned by the state laws now in place, those rights are best sacrificed in the larger interest of preserving appearances.

But surely the Constitution does not permit the State to sacrifice the rights of the dying on the altar of appearances. However well-tailored the State's ban is to the achievement of this goal, it cannot be doubted, in a nation committed not to regulation by winks and nods but to the rule of law — indeed in a nation committed to the democratic accountability of its governmental officials, see *New York* v. *United States*, 505 U.S. 144, 182-183 (1992) — that a state's interest in *appearing* to protect life in a way that it does not actually protect it is neither sufficiently "substantial" nor sufficiently "important" to outweigh a terminal patient's liberty to avoid a horrific death. Indeed, there is no more fixed constitutional principle than that the government has *no* interest in restricting the awareness of its citizenry. See, *e.g.*, *44 Liquormart, Inc.* v. *Rhode Island*, 116 S.Ct. 1495, 1508 (1996) (Stevens, J., joined by Kennedy and Ginsburg, JJ.); *id.* at 1515-1520 (Thomas, J., concurring in part and concurring in the judgment).[23]

This Court is also urged not to recognize a right to end suffering, essentially because it would result in regulation of *all* the death-causing medical treatment in which the State now permits physicians to engage. The AMA argues that "the unprecedented intrusion into the physician-patient relationship needed independently to regulate such treatment decisions would" be "all too likely to undermine what progress has been made in decisions to withdraw or withhold life-sustaining treatment and to use effective pain control," AMA Br. 17; see also *id.* at 22 (if the "boundary is lost, much support for . . . withdrawing treatment . . . may be lost as well").

But the State can have no legitimate interest in protecting doctors

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[23] There is of course all the difference in the world between ending practices that lead to a profession's bad reputation, see *Florida Bar* v. *Went For It, Inc.*, 115 S.Ct. 2371, 2376 (1995), and employing the law to *cover up* existing practices that one fears may have that same effect — a choice that no view of the First Amendment could sanction.

from what all must concede to be not only appropriate but necessary regulation. The interest in physician freedom cannot justify the indignity and brutality of the way the State insists that those with intractable end-of-life pain and distress must be prepared to die.

III. THE LINES DRAWN BY THE STATE OF NEW YORK ARE ARBITRARY AND IRRATIONAL AND SO VIOLATE THE EQUAL PROTECTION CLAUSE

Even if this Court were to conclude that there is no protected liberty here — or were it to desire not to reach that constitutional issue — the judgment below should still be affirmed, because the distinctions drawn by New York law are irrational, and so violate equal protection even under the scrutiny applicable when no independently protected liberty is involved.[24]

"In applying the Equal Protection Clause to most forms of state action, we . . . seek only the assurance that the classification at issue bears some fair relationship to a legitimate public purpose." *Plyler* v. *Doe*, 457 U.S. 202, 216 (1982). But although "[a] legislature must have substantial latitude to establish classifications" that "accommodate competing concerns both public and private, and that account for limitations on the practical ability of the State to remedy every ill," *id.*, a distinction drawn in the law "must be reasonable, not arbitrary, and must rest upon some ground of difference having a fair and substantial relation to the object of the legislation." See *Eisenstadt*, 405 U.S. at 447 and n. 7 (quoting *Reed* v. *Reed*, 404 U.S. 71, 75-76 (1971) (internal quotation marks and citation omitted)).

As this Court's precedents make clear, this standard, though deferential, does not amount to judicial abdication. Applying it, this Court has never shied away in appropriate circumstances from

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[24] Of course, if this Court concludes that the laws at issue in this case intrude on a constitutionally protected liberty — or that the political process is systemically incapable of adequately protecting the interests of the dying, see Resp. Br. in *Glucksberg* 39 n. 26 — those laws would violate equal protection because, as shown above, see *supra* pp. 35-43, the State has failed to show that the distinctions drawn by its laws are narrowly tailored to serve a compelling state interest.

invalidating arbitrary classifications and legislation. See, *e.g.*, *Romer* v. *Evans*, 116 S.Ct. 1620, 1627-1629 (1996); *Allegheny Pittsburgh Coal Co.* v. *County Commission of Webster County*, 488 U.S. 336, 344-346 (1989); *City of Cleburne* v. *Cleburne Living Center*, 473 U.S. 432, 447-450 (1985); *Hooper* v. *Bernalillo County Assessor*, 472 U.S. 612, 619-623 (1985); *Eisenstadt*, 405 U.S. at 447-455; *Reed*, 404 U.S. at 75-77.

A. The Distinction Between Withdrawal of Life-Sustaining Treatment and the Provision of Life-Ending Medication, As Drawn By New York Law in the Context of Intentionally Death-Causing Behavior, is Not Rational

Even assuming the State had asserted a legitimate interest in compelling a dying patient to keep suffering against her will, the principal line drawn by state law is both arbitrary and irrational. The State purports to prohibit doctors from assisting their patients to die with dignity when they are in the final stages of terminal disease and are intolerably suffering. Thus a doctor may not assist such a patient by providing life-ending medication for her own administration even when, in the physician's professional opinion, it is medically and psychiatrically appropriate. Yet the State permits doctors deliberately to assist such patients to die if they can do so by withdrawing life-sustaining treatment, including artificially provided food and water.

The decision in this context to distinguish those who are on life-sustaining treatment from those who are not simply cannot be justified. The State treats them differently "on the basis of criteria wholly unrelated to the objectives of th[e] statute[s]" at issue. *Reed* v. *Reed*, 404 U.S. at 76. As applied to acts equally intended to facilitate death, the line cannot be defended on the ground of a difference of intent. See Pet. Br. 15-16. For, as described above, although the State refuses to *characterize* the intent of the patient in the former case as an intent to die, the legal distinction does not depend on any difference in *actual* intent between the patients the doctors are permitted to assist to die and those whom they are not. See *Colorado Republican Campaign Committee* v. *F.E.C.*, 116 S.Ct. 2309, 2319 (1996) (Breyer, J., joined by O'Connor and Souter, JJ.) (the government's "characterization" of its actions cannot control

"for constitutional purposes"); *id.* at 2321-2322 (Kennedy, J., joined by Rehnquist, C.J., and Scalia, J., concurring in the judgment and dissenting in part) ("[W]e cannot allow the Government's suggested labels to control our [constitutional] analysis.").

Nor can a distinction in "causation" between "natural" death and death by human "intervention" justify the line drawn by the State. Pet. Br. 17-18. Petitioners argue that one who is disconnected from life-sustaining treatment "is letting nature take its course" in that "[h]is death is caused by the underlying disease or disorder." *Id.* But this Court has recognized that is not the case. See *Cruzan*, 497 U.S. at 280 (referring to "hav[ing] hydration and nutrition withdrawn in such a way as to cause death"). And even New York law does not pretend it is true: Any doctor who disconnected a person from life-support *without* informed consent could be prosecuted for committing homicide by "causing" the patient's death; and any doctor who disconnected from life-support a patient who requested such action in order to die but was otherwise likely to recover could be prosecuted for assisting a suicide. Moreover, as the court below observed,

> there is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. . . . It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

Pet. App. 30a. See also *Cruzan*, 497 U.S. at 296-297 (Scalia, J., concurring).

Nor can the line drawn by New York be defended on the basis that those individuals whom the State permits to obtain a physician's help in dying, and only those individuals, are "being subjected to an ongoing bodily intrusion" and, "just as they could have refused the intrusion, they can withdraw their consent at any time," so that it is neither their "terminal illness" nor any positive action or decision of the State but simply "the now undesired bodily intrusion" that "empowers" them to end their lives by "refus[ing] further treatment" and having life-support removed. Br. for Bioethics Professors

Supporting Petrs. 14.

A desire to permit patients to effect the termination of bodily intrusions simply cannot justify the line drawn by the State. First, as we have seen, see *supra* pp.10-11, the State does not *always* permit the life-ending withdrawal of treatment by non-terminal patients whose intent is to die. Second, patients currently "on" life-support and those who are not both may have had bodily intrusions which are ongoing and for which they have given consent: an artificial heart valve, a kidney or a bone marrow transplant, for example. These are considerable bodily invasions that change the patient inalterably, and may transform the nature of her death.

Such patients may wish to die by withdrawing their consent to the bodily intrusion to which they have been subjected. But their cases demonstrate that the State's line is not about permitting patients to undo a battery. Even where withdrawal of consent is theoretically possible, the State would doubtless say that a patient has no right to end his own life by insisting, for example, that surgeons remove a donor kidney or heart that had already been implanted. On the other hand, if the State *did* permit this type of life-ending physician assistance, how could it argue that it is rational not to permit the same patient to obtain a lethal dose of medication from a physician for the same ultimate purpose?

Nor, finally, can the line be defended on the basis of a difference — whether in kind or degree — in the risks involved. As we have shown, all the risks of error and coercion are at least as great with respect to what the State permits as to what it forbids. See *supra* pp. 38-39. Likewise, the argument from medical necessity — that patients will not endure technologically-advanced treatments without the option of voluntarily seeking physician assistance in dying — applies with the same force on both sides of the state-drawn line. See *supra* p. 37.

Indeed, the very way the line developed underlines the impossibility of defending it. The statutes at issue in this case admit by their terms of no exceptions for those receiving life-sustaining treatment. Those exceptions are part of the gloss put on the statutes by a series of decisions of the New York courts. Because the resulting legal regime is thus not a reflection of any coherent legislative judgment — because it does not "establish classifications that accommodate competing concerns both public and private,"

Plyler v. *Doe*, 457 U.S. at 216 — it is hardly surprising that petitioners' *post hoc* rationalizations of the lines drawn by the State fall so far short of the mark. Cf., e.g., *United States* v. *Virginia* 116 S.Ct. 2264, 2275 (1996) (rationales offered only in hindsight not credited). Yet the fact that the line at issue here may in this sense be explicable as an historical vestige cannot itself save it. For even when the historical record can *explain* an anomaly, "an explanation is not the same as a justification." *Norman* v. *Reed*, 502 U.S. 279, 294 n. 10 (1992). See also, *e.g.*, *Allegheny Pittsburgh Coal Co.*, 488 U.S. at 344-346 & n. 4 (when a policy that might be sound in the abstract is applied in an "aberrational" way that creates an irrational disparity, it violates equal protection); accord *Nordlinger* v. *Hahn*, 505 U.S. 1, 15 (1992) (upholding similar scheme that was intentionally adopted).[25]

B. The Distinction Between Terminal Sedation and Prescription of Life-Ending Medication is Not Rational

If any doubt were to remain as to the irrationality of the line New

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[25] The United States attempts to establish that New York's legislature has deliberately chosen to "preserve the distinction" between "refusing unwanted medical treatment" and "assisted suicide." Govt. Br. 16-17. The events to which it points do not support this contention. There is no evidence that the failure in 1965 to *delete* the assisted suicide laws was a reflection of any conscious thought whatever. Pet. App. 41a n. 6. The 1987 Orders Not to Resuscitate Act has nothing to do with the distinction to which the United States refers. Finally, the 1990 Health Care Agents and Proxies Act actually acknowledges the judicial decisions permitting the life-ending withdrawal or withholding of artificially-supplied food and water, explicitly permitting health-care agents to decide about this, provided the wishes of the principal are known to the agent, N.Y. Public Health Law §2982(2). The legislative caveat quoted by the United States, Govt. Br. 18, merely makes clear that the legislation was not intended as a substantive expansion of the rights recognized by the New York courts. See N.Y. Pub. Health Law § 2989.

Because the line drawn by the State here has endured merely through legislative inertia, this Court's deference is certainly less warranted. Indeed, the lack of evidence of "careful [legislative] consideration" and the doctrines requiring this Court to "avoid unnecessary, or unnecessarily broad, constitutional adjudication," *Thompson v. Oklahoma*, 487 U.S. 815, 857-858 (1988) (O'Connor, J., concurring in judgment), warrant consideration of the approach advocated by Judge Calabresi in the court below. Pet. App. 35a-62a.

York has drawn between those who are on life support and those who are not, the *other* line drawn by the State — in permitting physician assistance in the voluntary ending of the life of a person who is not (yet) on life-sustaining treatment, by the administration of terminal sedation followed by the withholding of nutrition and hydration, see AMA Br. in *Glucksberg* 10 ("sedation and withdrawal of treatment") — renders indisputably and utterly irrational the ban on physician provision, to identically-situated patients, of a simple, life-ending prescription.

Neither petitioners nor their *amici* attempt to defend this extraordinary distinction. Even if the State were found to be appropriately furthering some purpose by banning physician provision, to suffering terminally-ill patients, of requested life-ending prescription drugs while at the same time permitting those on life support to request assistance in the life-ending withdrawal of life-sustaining treatment, New York's regime would not be a rational means of serving any such purpose precisely because it exempts the procedure of physician-administered terminal sedation.

What purpose could possibly be "rationally" furthered by permitting one who is not dependent on life support to seek physician assistance to end his own life — but only if he is willing to do so in a way that is horrific and cruel: by consenting to be made unconscious, rendering him dependent on life support (in the form of artificial nutrition and hydration) if he is to remain alive, and then deliberately causing his own death by having a physician *withhold* it?

The permitted means of assistance — to induce barbiturate coma and then starve the person to death — is gruesome regardless of the patient's anesthetized state. For one who is *not* in a coma to be *rendered* unconscious — in order to permit the atrophy of a week- or two-week-long process of starvation and dehydration — is a profound affront to the dignity of the person. Indeed, this Court has recognized in the Eighth Amendment setting that, even for capital murderers sentenced to be punished by death, a method of ending life that involves "unnecessary pain," *Louisiana* v. *Resweber*, 329 U.S. 459, 463 (1947) (opinion of Reed, J.) or "a lingering death," *In re Kemmler*, 136 U.S. 436, 447 (1890), is unconstitutionally "cruel." See U.S. Const. Amend. VIII.

Literally every interest advanced by the State to defend its

prohibition on the prescription of life-ending drugs is present equally — if not more so — when the physician administers barbiturates to induce what is to be a terminal coma. Yet the State restricts only those who seek the former. There is no rational argument in favor of a legal scheme that permits a dying patient to obtain active assistance to end his life, but only if he does so in a way that is particularly gruesome or terrible or does profound dishonor to the human body and spirit, and that indeed entails a sacrifice of what all would presumably concede to be a constitutional right — the right *not* to be rendered unconscious and dependent.

Surely the State cannot permit assistance in dying only to those patients willing and able to endure the extreme hardship or further suffering involved in accepting terminal sedation. This distinction, drawn but not defended by the State of New York, essentially defines "caprice."[26] Particularly in light of the legal availability of terminal sedation, then, the criminal ban on the prescription of life-ending drugs cannot be upheld as a rational means of furthering any legitimate purpose.

CONCLUSION

The judgments of the Courts of Appeals here and in *Washington* v. *Glucksberg*, No. 96-110, should be affirmed.

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[26] Cf. *Carey* v. *Population Services International*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring in part and concurring in the judgment) ("It is as though a State decided to dramatize its disapproval of motorcycles by forbidding the use of safety helmets. One need not posit a constitutional right to ride a motorcycle to characterize such a restriction as irrational and perverse").

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

REPLY BRIEF FOR PETITIONERS VACCO AND PATAKI

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TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES ii

I. PLAINTIFFS MISCHARACTERIZE NEW YORK LAW WITH RESPECT TO ITS TREATMENT OF PATIENTS WHO EXERCISE THE RIGHT TO REFUSE OR WITHDRAW FROM MEDICAL TREATMENT 1

II. THE SUBSTANTIVE COMPONENT OF THE FOURTEENTH AMENDMENT DUE PROCESS CLAUSE DOES NOT ENCOMPASS A FUNDAMENTAL RIGHT TO OBTAIN THE ASSISTANCE OF A PHYSICIAN IN COMMITTING SUICIDE..... 3

III. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS A PERMISSIBLE MEANS OF VALIDATING ITS LEGITIMATE INTERESTS.. 10

IV. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE 18

CONCLUSION..... 20

TABLE OF AUTHORITIES

Cases PAGE

Collins v. City of Harker Heights, 503 U.S. 115 (1992) 4

Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) ..... *passim*

Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990) 2

Michael H. v. Gerald D., 491 U.S. 110 (1989) 4

Moore v. City of East Cleveland, 431 U.S. 494 (1977) 4

Personnel Administrator of Massachusetts v. Feeney, 442 U.S. 256 (1979) 18

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992) ..... *passim*

Poe v. Ullman, 367 U.S. 497 (1961) 4

Reno v. Flores, 507 U.S. 292 (1993) 3, 10, 17

Rivers v. Katz, 495 N.E.2d 337 (N.Y. 1986) 2

Rochin v. California, 342 U.S. 165 (1952) 5

Roe v. Wade, 410 U.S. 113 (1973) 6

San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1 (1973) 18

Schloendorff v. Society of New York Hospital, 105 N.E.2d 92 (N.Y. 1914) 5, 6

Storar, Matter of, 420 N.E.2d 64 (N.Y. 1981) 2

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PAGE

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United States Constitution

Fourteenth Amendment ..... *passim*

New York Statutes

Public Health Law § 2989(3) (McKinney 1993 & Supp. 1996) 19

Miscellaneous

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PAGE

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S. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 Duq. L. Rev. 455 (1996)..... 16

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REPLY BRIEF FOR PETITIONERS VACCO AND PATAKI

I. PLAINTIFFS MISCHARACTERIZE NEW YORK LAW WITH RESPECT TO ITS TREATMENT OF PATIENTS WHO EXERCISE THE RIGHT TO REFUSE OR WITHDRAW FROM MEDICAL TREATMENT

As a matter of law in New York, a mentally competent adult patient, whether or not terminally ill, has a right to be free of bodily intrusion and, as a corollary, can refuse or withdraw informed consent to medical treatment, including that

which is life-sustaining. *See, e.g., Fosmire v. Nicoleau*, 551 N.E.2d 77 (N.Y. 1990) (patient not terminally ill); *Matter of Storar*, 420 N.E.2d 64 (N.Y. 1981) (patient terminally ill). A physician may not proceed with treatment in such a circumstance. *Rivers v. Katz*, 495 N.E.2d 337, 342-43 (N.Y. 1986). Regardless of the presence of terminal illness, New York law honors the voluntary request of a competent patient to withdraw from or refuse medical treatment.

Plaintiffs are simply wrong in suggesting (Br. pp. 10-11) that New York inquires into the motivation of individuals who are not terminally ill and seek to exercise this right. Plaintiffs mischaracterize *Fosmire v. Nicoleau*, which held that a competent adult who had no terminal illness had the right to refuse life-sustaining blood transfusions. Although the Court of Appeals observed, as plaintiffs note, that the patient did not "want to die," 551 N.E.2d at 82 n. 2, this lack of intent to die was not the basis for its holding that the patient should have been permitted to refuse treatment. Rather, said the Court, although "[t]he State will intervene to prevent suicide," "merely declining medical care, even essential treatment, is not considered a suicidal act." *Id.* at 82.

This is hardly the same thing as "remaining neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 280 (1990). Thus, in *Von Holden v. Chapman*, 450 N.Y.S.2d 623 (4th Dept. 1982), the State was allowed to insert a nasogastric feeding tube in a prisoner in custody in a state psychiatric center who had refused to eat for 22 days but was receiving no medical treatment. Plaintiffs' characterization of the case to the contrary (Br. p. 11) is incorrect. *See id.* at 627 ("essential dissimilarity" of "right to decline medical treatment" and "right to take one's life").

There is thus no basis for plaintiffs' unsupported assertion (Br. pp. 11, 47) that "assisting one whose specific intent [is] to kill himself by the disconnection or termination of some life-sustaining treatment . . . could violate New York's law against aiding in suicide." Regardless of either the presence of terminal illness or the underlying intent, New York honors the voluntary decision of a competent patient to withdraw from or refuse medical treatment. *See infra* n. 3.

II. THE SUBSTANTIVE COMPONENT OF THE FOURTEENTH AMENDMENT DUE PROCESS CLAUSE DOES NOT ENCOMPASS A FUNDAMENTAL RIGHT TO OBTAIN THE ASSISTANCE OF A PHYSICIAN IN COMMITTING SUICIDE

Despite the highly charged and inconsistent terms used (Pl. Br. pp. 1, 3, 19, 24), the constitutional "right" plaintiffs are seeking is the right of mentally competent, terminally ill adults to obtain a physician's assistance in committing suicide (J.A. 28).[1] *See Reno v. Flores*, 507 U.S. 292, 302 (1993) (" 'substantive due process' analysis must begin with a careful description of the asserted right"). Any such asserted right is entitled to heightened constitutional protection under the substantive component of the Fourteenth Amendment's Due Process Clause only if it is " ' "so rooted in the traditions and conscience of our people as to be ranked as fundamental." ' " *Id.* (citations omitted). Whether viewed purely from the standpoint of historical practice or considered in terms of the substantive due process rights that have heretofore been protected by this Court, the asserted right to a physician's assistance in committing suicide cannot be deemed fundamental.

The simplest due process approach to this case is the one correctly taken by the court below. The Second Circuit, rec-

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[1] References to the Joint Appendix are cited as (J.A.). *Amicus curiae* briefs are cited as "Br. of ___." *Amicus curiae* briefs in *Washington v. Glucksberg*, No. 96-110, are cited as "Br. of ___ (Glucksberg)."

ognizing that fundamental liberties are only "those that are 'deeply rooted in this Nation's history and tradition,' " noted that "the very opposite is true" of the right asserted by plaintiffs (J.A. 231-232) (quoting *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)). Citing scholarship demonstrating that the English common law, the American colonies, and most states at the time of the enactment of the Fourteenth Amendment prohibited suicide and attempted suicide (J.A. 232-33), *see also* T. Marzen, et al., *"Suicide: A Constitutional Right?"—Reflections Eleven Years Later*, 35 Duq. L. Rev. 261, 262-268 (1996); Br. of Members of New York and Washington State Legislatures, pp. 8-23, the court then observed that most states today make assistance in suicide a crime, while no state has ever recognized a "right" to assisted suicide (J.A. 233).[2] Acknowledging the need to exercise restraint " 'because the guideposts for responsible decision-making in this uncharted area are scarce and open-ended,' " the Second Circuit properly declined "to identify a new fundamental right" (J.A. 233-34) (quoting *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992)). *See also Michael H. v. Gerald D.*, 491 U.S. 110, 122 n.2 (1989) ("[t]he protection need not take the form of an explicit constitutional provision or statutory guarantee but it must at least exclude . . . a societal tradition of enacting laws *denying* the interest").

Plaintiffs acknowledge "that most states historically have forbidden physicians to provide life-ending medication to their suffering patients" (Br. p. 27) but ask this Court to locate substantive due process rights in "historically enduring principles" as well as "concrete historical practices" (Br.

[2] In the past five years, the legislatures of fifteen states have debated the issue and decided to retain their prohibitions, and nine other states have strengthened their statutory prohibitions. Br. of Sen. Orrin Hatch et al., p. 25. Clearly, "the balance struck by this country," whether regarded in terms of "the traditions from which it developed" or "the traditions from which it broke," *see Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting), is overwhelmingly to prohibit physicians from prescribing medications for the purpose of causing death.

p. 22). Even if this Court accepts the invitation, the conclusion remains the same. The principles underlying this Court's prior recognition of substantive due process rights do not embrace a right to a physician's assistance in suicide.

Plaintiffs' argument rests primarily and unsuccessfully on this Court's decisions in *Cruzan* and *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Plaintiffs first contend (Br. pp. 19-21) that the asserted right of a "competent, terminally ill patient" to choose assisted suicide is congruent to the right recognized in *Cruzan*, which, according to plaintiffs, extends only to a seriously ill or dying person. There is no such limitation in *Cruzan*. The Court in that case mentioned that Nancy Cruzan had "virtually no chance of recovering her cognitive faculties," 497 U.S. at 265, purely as a descriptive matter. The right to withdraw from or refuse treatment extends to all. *See Schloendorff v. Society of New York Hospital*, 105 N.E.2d 92, 93 (N.Y. 1914) (Cardozo, J.). And as the *Cruzan* Court also made clear, the exercise of the right is readily distinguishable from any suicidal act, which may be prevented by the state. 497 U.S. at 280.

Plaintiffs' strained reading of *Cruzan* and the right it recognizes is evidenced also in their argument (Br. p. 25) that the recognition of "bodily integrity," 497 U.S. at 269, encompasses both a right to avoid bodily intrusion and a right to obtain "desired medical intervention."[3] But—as the cases cited by plaintiffs indicate and the word itself suggests[4]—"integrity" is a defensive right only. *See Washington v. Harper*, 494 U.S. 210 (1990) (right to avoid unwanted administration of antipsychotic drugs); *Rochin v. California*, 342

[3] Underlying plaintiffs' argument is the entirely unsupported proposition that the prescribing of drugs to kill a patient is a medical treatment. *See* Br. of American Medical Association, et al., pp. 4-5.

[4] The word derives from the Latin *integer*, meaning intact or untouched.

U.S. 165 (1952) (right to avoid forcible stomach pumping); *Schloendorff*, 105 N.E.2d 92 (common law right to damages for unconsented-to medical treatment). Indeed, this Court in *Casey* identifies *Cruzan*, *Harper*, *Rochin* and other cases only as "recognizing limits on governmental power to mandate medical treatment or to bar its rejection." *See* 505 U.S. at 857. This does not encompass or suggest a limitation on governmental power to prohibit death-causing intervention.

Nor is it true, as plaintiffs claim (Br. p. 29), that *Cruzan*'s recognition of a right to refuse treatment "can only be understood as a recognition of the liberty . . . to physician assistance in ending one's life." The individual interest at issue in *Cruzan* is not in death but in terminating treatment. *See* 497 U.S. at 279 ("a constitutionally protected right to refuse life-saving hydration and nutrition"); *id.* at 287 (O'Connor, J., concurring) ("a protected liberty interest in refusing unwanted medical treatment"); *id.* at 302 (Brennan, J., dissenting) ("a fundamental right to be free of unwanted life support"). While the Court in *Cruzan* notes that "[t]he choice between life and death is a deeply personal decision," the holding of the case is simply that the State "may legitimately seek to safeguard the personal element of this choice" with a heightened evidentiary standard. 497 U.S. at 281.

Plaintiffs' argument is not bolstered by reference to the recognition in *Casey* that the substantive due process right identified in *Roe v. Wade*, 410 U.S. 113 (1973), embraces both a right to choose and a right to avoid abortion. *See Casey*, 505 U.S. at 859. This shows, plaintiffs say (Br. p. 30), "that the liberty to make protected decisions is a two-way street." But this changes nothing about *Cruzan*, because the right to refuse treatment can by definition be exercised only defensively. In prohibiting assisted suicide, New York is not placing improper limits on which "way" the negative right in *Cruzan* will be exercised; there is only one way it *can* be exercised.[5]

[5] This is why plaintiffs' concerns about "a State deciding to prohibit extraordinary treatment for suffering patients who are about to die" (Br. p. 30) are inapposite. The fact that a negative right to refuse treatment can be exercised only in one "way" has no bearing on the viability of any positive right to receive or demand medical treatment.

See G. Scofield, *Exposing Some Myths About Physician-Assisted Suicide*, 18 Seattle U. L. Rev. 473, 479 (1995) (acknowledgement of "negative right" to refuse treatment does not create a duty to respect "positive right" to physician assisted suicide). Rather, the State is applying a prophylactic rule to a dangerous and hitherto-unrecognized positive "right."

Nor is plaintiffs' argument more persuasive when it moves further from *Cruzan* in the direction of *Casey*. *Casey*'s relevance to the present case is extremely problematic. The reaffirmance in *Casey* of a woman's constitutionally-protected liberty interest in choosing an abortion was based largely on "the rule of *stare decisis*." 505 U.S. at 845-46; *see also id.* at 866-67 (relying on "precedential force" of *Roe v. Wade*). Moreover, *Casey* rested in part on the importance of the right it recognized to the achievement of gender equality. *See id.* at 852 (state cannot "insist, without more, upon its own vision of the woman's role"); *id.* at 856 ("the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives"). *See also* R. Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1200 (1992) (emphasizing "the women's equality dimension of the issue" in *Roe* and *Casey*). No comparable interest applies to physician assisted suicide.

Casey cannot be relied on in the present case, as plaintiffs attempt (Br. pp. 23-25), for its recognition that substantive due process protects "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy" that "define the attributes of personhood," 505 U.S. at 851, or its understanding of the "intimate and personal" nature of a woman's "suffering." 505 U.S. at 851-852. This language, taken (as plaintiffs take it) literally

and out of the "unique" context of abortion, 505 U.S. at 852, would encompass a vast range of intimate personal decisions.

Plaintiffs implicitly recognize the potential for chaos in applying *Casey*'s language so literally. Thus, in an effort to assuage fears of widespread abuse, they define eligibility for the asserted right narrowly: one must be among the suffering terminally ill. In invoking *Casey*'s language, however, plaintiffs speak only in general terms of pain and personal autonomy, and liken the right they assert to other rights whose exercise is not limited to a specific segment of society. If, as plaintiffs suggest, the autonomy-based right to assistance in suicide can properly be exercised only by the terminally ill and "closely regulated" by the State, it is difficult to see how it can possibly be "fundamental."

Moreover, plaintiffs (Br. pp. 19-20) are suggesting that the terminally ill alone may obtain assistance in suicide because their quality of life is so diminished that "[t]he choice of how to die is the only choice left to [them]." This consolatory approach, requiring the creation of new rights when others cannot be exercised, is not how the acknowledgement of fundamental rights works. Nor is it apparent why this analysis limits the application of the right, for it can readily be said of anyone whose quality of life is, in his own or someone else's view, diminished in any significant way. And in any event, a judgment as to the "quality of life" is something that, according to this Court, a state need not make. *Cruzan*, 497 U.S. at 282. If a state may decline to make such a judgment, surely the Constitution does not require it to do so or to give effect to such a judgment.

Plaintiffs' argument that there is a fundamental right to assistance in suicide is undermined by an additional contradiction. On the one hand, they recognize the gravity and profundity of death and the irreducibly personal nature of dying. On the other hand, they suggest (Br. pp. 30-31) that "advances in medical technology" and "[t]he development of

increasingly sophisticated life-prolonging treatment" impart a new urgency to the right they assert. But the fact of death is a constant in nature and in human and American history. Neither its profundity nor its mystery nor its centrality has ever been deemed to justify a right to obtain assistance in committing suicide, even though the right to refuse treatment has always been recognized.[6] And though it may be that we die differently today than we did a hundred (or twenty) years ago, we do not necessarily die worse. Did death in an earlier age entail an end *less* "filled with life-encompassing pain, disintegration or suffering"? Given modern advances in pain relief and palliative care, it seems impossible, even when these advances are not fully deployed. *See generally* New York State Task Force on Life and the Law ("Task Force"), *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* ("*When Death Is Sought*") 35-47 (1994). Neither the misery nor the mystery of death is a new phenomenon. The law has always treated them with appropriate solemnity, yet they have never been deemed to give rise to a right, "fundamental" or otherwise, to obtain assistance in suicide.

The right to assistance in suicide that plaintiffs claim can be found nowhere in the text of the Constitution. Its exercise has always been, and continues to be, prohibited by the great majority of the states. Nor can it be derived from either the language or the holding of *Cruzan* or *Casey*. It is, in plaintiffs' own formulation, activated by precisely the supposedly diminished quality of life of the terminally ill that is not constitutionally cognizable. And it is compelled neither by the profundity and mystery of death nor by the particular circumstances of dying in contemporary America. However the

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[6] Plaintiffs suggest (Br. p. 32), absolutely without support, that "Due Process would not, in the 18th through mid-19th centuries, likely have been thought to include the right to avoid the artificial prolongation of life." On the contrary, as *Cruzan* recognized, the right derives unchanged from the English common law.

right to assistance in suicide is viewed, it is not "fundamental" and thus is not entitled to heightened protection under the Due Process Clause.

III. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS A PERMISSIBLE MEANS OF VALIDATING ITS LEGITIMATE INTERESTS

The proper approach to a substantive due process case is clearly articulated in *Reno v. Flores*.[7] Any state infringement of a fundamental right must be "narrowly tailored to serve a compelling state interest," while "[t]he impairment of a lesser interest . . . demands no more than a 'reasonable fit' between governmental purpose . . . and the means chosen to advance that purpose." *Reno v. Flores*, 507 U.S. at 302, 305. As demonstrated in the preceding section, the right asserted by plaintiffs is not "fundamental" in nature. Thus, as long as there is a "reasonable fit" between New York's purposes in prohibiting assisted suicide and the prohibition itself, the law is not unconstitutional.

The interests asserted by New York demonstrate the reasonableness of its prohibition of assisted suicide. As discussed at length in the equal protection context in defendants' main brief (pp. 20-26), the State asserts the interest in "the protection and preservation of human life" that, according to *Cruzan*, justifies state "laws imposing criminal penalties on

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[7] The standard by which to judge the validity of New York's prohibition does not, as plaintiffs argue (Br. p. 34), derive from *Casey*. The plurality opinion in that case affirmed the conclusion of *Roe v. Wade* that women have a substantive due process right to abortion that can be limited only by state regulation that does not impose an "undue burden" on or a "substantial obstacle in the path of" the exercise of that right. *Casey*, 505 U.S. at 877. *Casey*'s approach presupposes a substantive right that is deemed "fundamental" under the Due Process Clause, a right not found here. And if, as the United States Solicitor General proposes, the "undue burden" standard is something less than strict scrutiny, then New York's prohibition survives that review because, as plaintiffs have conceded (Br. p. 37), the State's interests are compelling.

one who assists another to commit suicide." 497 U.S. at 280. Plaintiffs now argue (Br. p. 35) that the State's interest is "fatally undermined" by its authorization of "the life-ending withdrawal of treatment." As *Cruzan* makes clear, however, the criminalization of assisted suicide can coexist with the right to terminate treatment, which derives from the common law of informed consent, may be exercised by the terminally ill or anyone else, and cannot be absolutely prohibited by a state. *See Cruzan*, 497 U.S. at 270, 279, 281-82.

This analysis does not change when the use of drugs with a "double effect" is considered. As medical literature cited by plaintiffs demonstrates, physicians recognize "the primacy of comfort as the dominant goal of care." N. Cherney & R. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31, 35 (1994). Sometimes, achievement of this goal requires that a physician administer a pain-relieving drug in doses large enough to have the possible side effect of fatal depression of respiration. This potential "double effect" is accepted throughout medicine, and is acknowledged, for example, whenever physicians perform surgery that entails (or involves the use of an anaesthetic that entails) a foreseeable risk of unintended death. Because the physician's purpose is to cure or palliate rather than kill, administration of the drug is not assisted suicide.

Similarly, patients near death occasionally suffer such "refractory" pain that the primary goal of "adequate relief of intolerable symptoms" requires "impair[ment] of the [patient's] conscious state." *Id.* at 34. The physician administers a sedative—an opioid, a benzodiazepine, or (rarely) a barbiturate—which provides relief but increases the risk of accelerating death. *Id.* at 35. Again, this is no different from any other medical procedure that balances the frequently incompatible goals of "prolonging survival," "optimizing comfort" and "optimizing function." *Id.* at 34. Sometimes, too, a physician will administer a sedative prior to fulfilling

a patient's informed and competent request to terminate life-prolonging treatment, *see* R. Truog, et al., *Barbiturates in the Care of the Terminally Ill*, 327 New Eng. J. Med. 1678, 1680 (1992), thus properly minimizing the patient's suffering. But plaintiffs' repeated suggestion (Br. pp. 15-16, 49-50) that a patient may "consen[t] to be made unconscious, rendering him dependent on life support . . . and then deliberately caus[e] his own death by having a physician withhold" life-sustaining treatment is utterly without support in the record and unquestionably outside the bounds of accepted medical practice.

Indeed, the very article on which plaintiffs rely for the concept of "terminal sedation" rejects any notion that it is a practice used to cause or induce death:

> Although proponents of physician-assisted suicide and euthanasia contend that terminal sedation is covert physician-assisted suicide or euthanasia, the concept of sedating pharmacotherapy is based on informed consent and the principle of double effect.

P. Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Arch. Intern. Med. 1785, 1785-86 (1996). The predicate for terminal sedation is "refractory" physical and psychosocial symptoms, that is, symptoms that are unresponsive to treatment. *Id.* "Although relief of symptoms with a preserved function is the usual goal of medicine . . . relief of suffering may predominate over all other considerations, including maintenance of consciousness." *Id.* But the practice contemplates only the level of medication required to control symptoms, and thus not all will be rendered unconscious. *Id.* Finally, the practice envisions only a "current do-not-resuscitate order" so that when death arrives, unwanted life-prolonging measures are not used. *Id.*

At least as important as the State's interest in protecting human life is its interest in avoiding error and abuse. As plaintiffs themselves note (Br. p. 37), "the protection of

people who might seek to end life mistakenly or under pressure is a compelling interest." The dimensions of this interest are discussed at length in defendants' main brief (pp. 27-32) and many *amicus* briefs, and will only be summarized here: the risk of error inherent in any determination of "terminal" illness, given the absence of any clear-cut definition of the term and the facts that doctors typically make poor judgments about the period of life remaining to the terminally ill and that their prognoses of survival time fail to account for variations in treatment, *see* Br. of American Geriatrics Society, pp. 16-21, National Hospice Organization, pp. 14-15; the impossibility of reliably measuring pain or suffering if they are to be aspects of a valid exercise of the right to assistance in suicide, *see* Br. of American Geriatrics Society, p. 25; the problematic nature of the voluntariness of a request for suicide and the competence of one who makes such a request in light of the possibility of inadequately-treated pain or undiagnosed and undertreated depression, *see* Br. of Project on Death in America, et al., pp. 15, 23, American Medical Association, et al., p. 13, American Geriatrics Society, p. 21; the erosion of voluntariness attributable to overwhelming financial pressures, whether exerted by families or by managed care organizations, with their strong economic incentives to limit medical treatment, *see* Br. of International Anti-Euthanasia Task Force, *passim*, American Medical Association, et al., p. 13, Project on Death in America, p. 20; the same concern about voluntariness due to the imbalance and dependency inherent in the physician-patient relationship, *see* Task Force, *When Death Is Sought* at 73, 121; the fact that the risk of error and abuse is enhanced for the poor and minorities, who are especially likely to receive inadequate diagnosis and treatment and especially vulnerable to financial pressures, *see* Br. of American Medical Association, et al., p. 13; and the fact that any regulation of decisions about assisted suicide would require an unprecedented intrusion into the physician-patient relationship, *see* Br. of American Medical Association, et al., p. 17.

Plaintiffs acknowledge the legitimacy of these concerns, but suggest (Br. pp. 37-38) that they do not "require a complete ban on the provision of life-ending medication" to those with "the right to self-administer such a prescription drug." The sole possessor of such a right, according to plaintiffs (Br. p. 21), is the "competent, terminally ill patient [who may] choose whether to endure a death marked by intolerable agony, degradation, and suffering." Plaintiffs reject the possibility that the freedom they claim will perforce be extended to others who (they agree) do not have a constitutional right to exercise it. On the other hand, they insist (Br. p. 38) that the fact that New York limits but does not ban the withdrawal from life-prolonging treatment means that "less restrictive measures" than an outright prohibition must be employed to regulate assisted suicide as well.

Plaintiffs' argument collapses under the weight of this contradiction. As noted in defendants' main brief (pp. 21-24), if the justification for invalidating New York's ban is the equivalence between assisted suicide and termination of treatment, then the right claimed by plaintiffs simply cannot be limited as they say it must be in order to survive constitutional scrutiny. If, however, the right can be exercised only upon the error-prone determination of far more factors than are entailed in deciding whether to give effect to a request to withdraw from life-prolonging treatment, then the greater risk of error connected with physician assisted suicide justifies New York's prohibition of it.

Even if plaintiffs were somehow correct in suggesting that the "right" to assistance in suicide can be limited to the terminally ill, they remain wrong in the central assertion of their argument (Br. pp. 38-39): that "[t]he precise risks about which the State claims to be concerned [with respect to assisted suicide] are of course equally present" in decisions to withdraw from life-prolonging treatment. For several reasons, the risks are greater with physician assisted suicide.

First, patients wishing to terminate life support are, by definition, already receiving substantial medical care, whereas those who choose assisted suicide may be doing so in lieu of unavailable or inadequate medical attention. Br. of American Geriatrics Society, p. 12. The risk of error and involuntariness due to, for example, inadequate pain control or undiagnosed and untreated depression is thus far greater with assisted suicide, even among the terminally ill.

Moreover, severely ill persons who wish to kill themselves share with other suicidal individuals a clinical profile characterized by depression and extreme anxiety, whereas such a profile is not typical of seriously ill patients who elect to terminate life-supporting medical interventions. *See* Br. of American Suicide Foundation (*Glucksberg*), pp. 5-15. In other words, when comparing risks, a terminally ill patient's choice of suicide is substantially less likely to be truly voluntary than a terminally ill patient's choice to terminate treatment.

Furthermore, as demonstrated by the amicus brief of the American Geriatrics Society (pp. 16-21), predictions of death from the natural course of serious illness can be formulated only as probability judgments encompassing a wide range of time spans for virtually all serious illnesses.[8] This inherent uncertainty of prognostic data severely undermines plaintiffs' case, which distinguishes those in "the final stages of a terminal illness" by virtue of the supposed certainty of their imminent deaths. An individual who discontinues treatment because he mistakenly thinks death is imminent may well, as plaintiffs put it, survive and "live to rejoice" (Br. p. 20). But many individuals who request assistance in suicide on the basis of the same, inherently unreliable information will have

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[8] For example, "the actual survival curve for persons with less than a 50% chance to live six months" according to one prognostic model reveals that most "terminal" illnesses have "a substantial 'tail' of long term survivors: more than one-fifth of some patient groups are alive after two years." J. Lynn, et al., *Defining the 'Terminally Ill:' Insights from SUPPORT*, 35 Duq. L. Rev. 311, 320 (1996).

their lives cut needlessly short. These differences in the risk attendant upon the uncertainty of a prognosis of terminal illness justify New York's prohibition of assisted suicide while it permits termination of treatment.

The prevalence of managed care increases the risk of error by and abuse of patients who choose suicide relative to those who withdraw from treatment. The brief *amicus curiae* of the International Anti-Euthanasia Task Force (p. 30) notes the cost-effectiveness of "managed death." To put it bluntly, it is cheaper to kill patients at once than to treat them at length. As one article notes, patients may raise the possibility of assisted suicide early in the disease process, perhaps upon "the initial announcement . . . of a frightening diagnosis," whereas discussions and decisions substantially in advance of death about terminating life-prolonging treatment are uncommon, despite efforts to promote earlier decision-making. S. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 Duq. L. Rev. 455, 474 (1996). Moreover, research that projects savings from such termination "has concluded those savings are modest at best," perhaps because those who terminate life-prolonging treatment then require costly palliative care instead. *Id.* at 475. Thus, there are significant financial incentives in the one situation that are often not present in the other.

Nor are the risks which would accompany legalization of assisted suicide speculative, for as noted in defendants' main brief (p. 24 n. 13), the actual experience of the Netherlands with euthanasia and assisted suicide is instructive. First, it is abundantly clear that Dutch guidelines designed to assure, *inter alia*, the voluntariness of the choice of death are frequently neglected. *See, e.g.*, L. Kass & N. Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 412-13 (1996). Furthermore, the very article upon which plaintiffs rely to dismiss defendants' concerns about adoption of the Dutch approach reveals that in 1995, 0.7 percent of deaths in the

Netherlands involved ending a patient's life without his or her explicit request. P. van der Maas, et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New Eng. J. Med. 1699, 1700 (1996). The equivalent in the United States, where there are 2.3 million deaths annually, is more than forty deaths a day attributable to nonvoluntary euthanasia.[9] The risk is very real.

Thus, no matter what the scope of the asserted "right," whether extended only to the terminally ill or otherwise, New York may ban its exercise entirely. *Cruzan* observes that even as a state must recognize the right to refuse medical treatment, it may assert its interest in the protection of human life by prohibiting assistance in suicide. Moreover, there are many reasons to believe that the risk of error and abuse is significantly greater with assisted suicide than with withdrawal from treatment, especially under the regime of managed care that increasingly dominates the provision of health care services in America. These state interests are concededly not only rational but compelling. The difference in nature and risk between assisted suicide and withdrawal from life-prolonging treatment means that prohibiting the former while allowing the latter "is not excessive in relation to th[ose] valid purpose[s]." *Reno v. Flores*, 507 U.S. at 303. Accordingly, New York's ban on assisted suicide does not violate the substantive component of the Due Process Clause.

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[9] Plaintiffs, suggesting (Br. p. 41 n. 21) that there may be more such nonvoluntary euthanasia in the United States than in the Netherlands, cite a study suggesting that 7% of critical care nurses in the United States have engaged in nonvoluntary euthanasia, while ignoring the fact that 23% of Dutch physicians have done so. *See id.* at 1701. Moreover, the study they cite has been widely and severely criticized for its methodological flaws. *See, e.g.*, C. Scanlon, *Euthanasia in Nursing Practice—Right Question, Wrong Answer*, 334 New Eng. J. Med. 1401 (1996).

IV. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE

The foregoing discussion leaves little to add to the exploration of the equal protection issue in defendants' main brief. The assumed existence of a substantive due process right to withdraw from life-prolonging treatment does not suggest an equivalent right to assistance in suicide. *See San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33 (1973) ("it is not the province of this Court to create substantive constitutional rights in the name of guaranteeing equal protection of the laws"). New York law, of course, makes no "classification" of the sort essential for equal protection analysis. All New Yorkers may exercise the right to terminate unwanted medical treatment; none may exercise the "right" to assist or be assisted in suicide. New York's policy thus cannot violate the Equal Protection Clause. *See, e.g., Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 271-274 (1979) (disproportionate negative impact of facially neutral and otherwise valid state law does not violate equal protection unless it affects a historically-disadvantaged group and was enacted for a discriminatory purpose); Pl. Br. p. 10 (acknowledging that terminating treatment is not viewed under New York law as a suicidal act).

But even if New York's approach is deemed a "classification," it survives constitutional scrutiny. As plaintiffs concede (Br. pp. 44-45), the Equal Protection Clause requires in the present case only that a statutory classification be rationally related to a legitimate state purpose. Like the court below, plaintiffs rely (Br. p. 45) on the supposed similarities between "providing life-ending medication" and "withdrawing life-sustaining treatment." For the reasons discussed in defendants' main brief and in the preceding section of this brief, however, assisted suicide and withdrawal from life-prolonging treatment differ both inherently and with respect to the risks they present. It was reasonable for the New York Legislature to consider these differences and prohibit one practice while permitting the other.[10] *See* Pl. Br. p. 37 (State's interests in preventing abuse and mistake are "compelling").

We note in conclusion that the balance struck by the New York Legislature between the exercise of individual autonomy by those who truly want to commit suicide and the protection of the many vulnerable citizens who do not is desirable but not inevitable. The fact remains, however, that never once in American history has a patient lawfully obtained a physician's assistance in committing suicide. A declaration that there is a right to do so would be a leap—from near universal prohibition to constitutional obligation—unprecedented in this Court's history. There is no basis for such a leap.

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[10] Plaintiffs' argument (Br. p. 48 n. 25), following the concurrence of Judge Calabresi in the court below, that there is no evidence of recent legislative consideration of the issues in this case, is belied by, *inter alia*, (1) the 1990 enactment of the New York Health Care Proxy Act, which permits a "health care agent" to make decisions about withdrawal of artificial nutrition and hydration, but "is not intended to permit or promote suicide, assisted suicide, or euthanasia," N.Y. Pub. Health L. § 2989(3) (McKinney 1993 & Supp. 1996); and (2) the presentation in 1994 to the Legislature of the report of the Task Force, *When Death Is Sought*, which unanimously recommended that the law not be changed to permit assisted suicide, *see When Death Is Sought* at xii.

CONCLUSION

THE JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT SHOULD BE REVERSED WITH RESPECT TO ITS EQUAL PROTECTION HOLDING AND OTHERWISE UPHELD.

Dated: Albany, New York
December 24, 1996

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In the Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, ET AL., PETITIONERS

v.

TIMOTHY E. QUILL, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTION PRESENTED

Whether a State that allows competent, terminally ill persons to refuse life-sustaining medical treatment violates the Equal Protection Clause if it makes it unlawful for physicians to prescribe lethal dosages of medication for use by such persons who request the medication for the purpose of ending their lives.

TABLE OF CONTENTS

	Page
Interest of the United States	1
Statement	3
Summary of argument	7
Argument:	
I. A State may conclude that important state interests justify prohibiting physician assisted suicide while permitting the refusal of medical treatment	8
II. The New York statutory prohibition of assisted suicide sufficiently reflects a contemporary legislative judgment	16
Conclusion	19

TABLE OF AUTHORITIES

Cases:

Colyer, In re, 660 P.2d 738 (Wash. 1983)	11
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F.S. Royster Guano Co. v. *Virginia*, 253 U.S. 412 (1920)	8
McKay v. *Bergstedt*, 801 P.2d 617 (Nev. 1990)	11
Plyler v. *Doe*, 457 U.S. 202 (1982)	8
Thor v. *Superior Court*, 855 P.2d 375 (Cal. 1993)	10
Tigner v. *Texas*, 310 U.S. 141 (1940)	8

Constitution and statutes:

U.S. Const. Amend. XIV	1, 3, 8
Due Process Clause	3
Equal Protection Clause	1, 3, 5, 8
Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193	16
Act of July 20, 1965, ch. 1030, 1965 N.Y. Laws 1544	16

Statutes—Continued: Page

Act of Aug. 7, 1987, ch. 818, § 1, 1987 N.Y. Laws 1526 17
Act of July 22, 1990, ch. 752, § 2, 1990 N.Y. Laws 1538 17
Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, § 4206(a)(2), 104 Stat. 1388-115 2
42 U.S.C. 1395cc(f) 2
N.Y. Penal Law (McKinney 1987):
§ 35.10(4) 16
§ 120.30 ..... 3, 16
§ 125.15(3) 3, 16
N.Y. Pub. Health Law:
§§ 2960-2979 (McKinney 1993 & Supp. 1996) 17
§ 2982(1) (McKinney 1993) 17
§ 2989(3) (McKinney 1993) 18

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Miscellaneous—Continued: Page

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Mildred Solomon, et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14 (Jan. 1993) 11

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INTEREST OF THE UNITED STATES

This case raises the question whether the Equal Protection Clause of the Fourteenth Amendment permits a State to prohibit a physician from prescribing lethal dosages of medication for a competent, terminally ill adult who requests such medication for the purpose of ending his life, while allowing a competent, terminally ill adult to refuse or discontinue artificial life support. The court of appeals concluded that such competent, terminally ill adults are similarly circumstanced and that the State has insufficient justification for distinguishing between the

prescription of lethal medication and the termination of life-sustaining medical treatment, including the withdrawal of hydration, feeding tubes, respirators, and similar devices. See Pet. App. 29a-33a.

The United States owns and operates numerous health care facilities that permit patients to refuse life-sustaining treatment, but do not permit physicians either to administer or to prescribe medications for the purpose of ending a patient's life. For example, the Department of Veterans Affairs (VA) operates 173 medical centers, 126 nursing homes, and 55 in-patient hospices. A VA policy manual generally permits the withholding and withdrawal of life-sustaining treatment in response to a patient's request, but prohibits "the active hastening of the moment of death." Department of Veterans Affairs, Manual M-2 ¶ 31.08(c) (Nov. 1991). Similarly, the VA's hospice program guide states that "[t]he hospice philosophy does not condone nor participate in any action intended to hasten * * * the patient's death." Department of Veterans Affairs, Veterans Health Admin., Program Guide 1140.10: Hospice Program ¶ 1.02(b) (Sept. 1996). A similar practice is followed by the military services, which operate 124 medical centers, the Indian Health Service, which operates 43 hospitals, and the National Institutes of Health, which operate a clinical center.

In addition, Pub. L. No. 101-508, § 4206(a)(2), 104 Stat. 1388-115, requires all health care providers receiving Medicaid or Medicare first, to inform all competent adults about state laws concerning the right of patients to refuse life-sustaining treatment and second, to record any advance directives the patient might have. 42 U.S.C. 1395cc(f). No federal law authorizes or encourages physician assisted suicide.

The United States therefore has a substantial interest in the resolution of the question presented in this case.

STATEMENT

1. Under New York law, "[a] person is guilty of manslaughter in the second degree when * * * [h]e intentionally causes or aids another person to commit suicide." N.Y. Penal Law § 125.15(3) (McKinney 1987). Similarly, he is "guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." *Id.* § 120.30. Three terminally ill patients and three physicians who treat terminally ill patients filed suit in the United States District Court for the Southern District of New York alleging that those statutes violate the Due Process and Equal Protection Clauses of the Fourteenth Amendment to the extent that they bar physicians from prescribing lethal dosages of medication for mentally competent, terminally ill patients who request this medication for the purpose of ending their lives.

At the time of the filing of the complaint, each of the patient plaintiffs was a mentally competent adult in the final stages of a terminal illness. Patient Jane Doe, a retired teacher, suffered from a thyroid cancer that made it necessary to implant a feeding tube in her stomach; she was unable to reduce her pain to a manageable level. Pet. App. 5a, 7a-8a. Patient George A. Kingsley, a publishing executive, was infected with AIDS and suffered a host of related illnesses, including parasitic infections that caused brain lesions, pain, diarrhea, exhaustion and wasting, and a virus that was robbing him of his sight. *Id.* at 5a, 8a-9a. Patient William A. Barth, a former fashion editor,

also suffered from AIDS and related illnesses, including skin cancer, pneumonia and parasitic infections that caused diarrhea, fevers, wasting and "pain and suffering" that he could "no longer endure." *Id.* at 5a, 9a-10a. Each sought "necessary medical assistance in the form of medications prescribed by [her or his] physician" in order to hasten death "in a certain and humane manner." *Id.* at 5a. Each died before the district court ruled on their motion for a preliminary injunction.

The physician plaintiffs alleged that they treated "mentally competent, terminally ill patients" who "experience[d] chronic, intractable pain and/or intolerable suffering." Pet. App. 5a. They alleged that, under certain circumstances, it would be consistent with the standards of medical practice to prescribe medications that these patients could self-administer in order to hasten death. *Ibid.*

The district court dismissed plaintiffs' claims. Pet. App. 63a-78a. It rejected their due process claim on the grounds that there was no fundamental liberty interest in physician assisted suicide. *Id.* at 76a. It then rejected their equal protection claim, finding a reasonable and rational basis to distinguish between the right to refuse medical treatment and the claimed right to physician assistance in committing suicide. Citing the State's interests "in preserving life, and in protecting vulnerable persons," as well as the State's "further right to determine how these crucial interests are to be treated," the court found it "hardly unreasonable or irrational for the State to recognize a difference between allowing nature to take its course, even in the most severe situations, and intentionally using an artificial death-producing device." *Id.* at 77a.

2. a. The court of appeals reversed. Pet. App. 1a-62a. The court found no substantive due process violation, concluding that the New York statutes do not infringe any fundamental liberty interest because assisted suicide is neither "so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed" nor "deeply rooted in the nation's traditions and history." *Id.* at 18a. The court held, however, that the statutes violate the Equal Protection Clause "because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." *Id.* at 35a. It concluded that "New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." *Id.* at 29a-30a.

The court found no legitimate state interest to support this difference in treatment. See Pet. App. 31a-34a. It dismissed the argument that the refusal of treatment allows a "natural" death or requires less action by the physician. *Id.* at 30a-31a. It then rejected the State's asserted interest in "preserving the life of all its citizens at all times and under all conditions," suggesting that this interest "lessens as the potential for life diminishes," and that the State has no interest in "requir[ing] the continuation of

agony when the result is imminent and inevitable." *Id.* at 31a.

Finally, the court concluded that the New York statutes do not serve any of the state interests identified by the Ninth Circuit panel in *Compassion in Dying* v. *Washington*, 49 F.3d 586 (1995), on reh'g en banc, 79 F.3d 790 (1996), cert. granted *sub nom. Washington* v. *Glucksberg*, No. 96-110 (Oct. 1, 1996). See Pet. App. 32a-34a. Those interests include preserving the role of physicians as healers, not killers; "avoiding psychological pressure upon the elderly and infirm to consent to death"; "preventing the exploitation of the poor and minorities"; "protecting handicapped persons against societal indifference"; "preventing the sort of abuse" found in the Netherlands, where physician assisted suicide is permitted and euthanasia occurs;[1] and avoiding difficulties that arise from the lack of a clear definition of the "terminally ill." *Id.* at 32a.

b. Judge Calabresi concurred in the result. Pet. App. 35a-62a. He concluded that, while the statutes still "nominally * * * forbid[]" physician assisted suicide, "the bases of these statutes have been deeply eroded over the last hundred and fifty years" and "few

[1] It is important to keep in mind the distinctions among (1) a patient's decision to decline or terminate unwanted medical treatment, including nutrition and hydration, even where that treatment may be necessary to sustain life; (2) the prescription by a physician of a lethal dosage of medication, to be self-administered by the patient, which is what is generally meant by the term "physician assisted suicide"; and (3) the administration by a physician of a lethal medication, referred to as "euthanasia." This case concerns only the second of these scenarios: physician-provided lethal medication. See Pet. App. 4a, 35a.

of their foundations remain in place today." *Id.* at 43a. Citing the "constitutional dubiety" of those statutes, he concluded that they could be upheld only on the basis of a "present and positive acknowledgment" by the legislature of the state interests at stake. *Id.* at 45a.

Based on his conclusion that the legislature "for many, many years * * * ha[d] not taken any recognizably affirmative step reaffirming the prohibition of what [respondents] seek," Pet. App. 44a, he would have held that, "on the current legislative record, New York's prohibitions on assisted suicide violate both the Equal Protection and Due Process Clauses of the Fourteenth Amendment * * * to the extent that these laws are interpreted to prohibit a physician from prescribing lethal drugs to be self-administered by a mentally competent, terminally ill person in the final stages of that terminal illness," *id.* at 62a. Judge Calabresi declined, however, to take a position on "whether such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes in the laws, and expressing the grounds for the prohibitions themselves." *Ibid.*

SUMMARY OF ARGUMENT

A state legislature, seeking to balance respect for individual patients' wishes against the protection of many patients' lives, may conclude that extremely important state interests justify a distinction between the refusal of unwanted medical treatment and the prescription of lethal dosages of medication for the purpose of ending life. Those interests include

preserving the distinction between killing a patient and letting a patient die; preventing the deaths of persons who are erroneously diagnosed as terminally ill; prohibiting a practice that is vulnerable to abuse or error and extremely difficult to police; and avoiding the greatest intrusions upon a patient's bodily integrity. Thus, a State does not violate the Equal Protection Clause of the Fourteenth Amendment by allowing a doctor to honor patients' directives to discontinue life-sustaining medical treatment while prohibiting a doctor from prescribing lethal dosages of medication for patients who request this medication for the purpose of ending their lives.

ARGUMENT

I. A STATE MAY CONCLUDE THAT IMPORTANT STATE INTERESTS JUSTIFY PROHIBITING PHYSICIAN ASSISTED SUICIDE WHILE PERMITTING THE REFUSAL OF MEDICAL TREATMENT

1. The Equal Protection Clause of the Fourteenth Amendment directs that "all persons similarly circumstanced shall be treated alike." *Plyler* v. *Doe*, 457 U.S. 202, 216 (1982) (quoting *F.S. Royster Guano Co.* v. *Virginia*, 253 U.S. 412, 415 (1920)). The Constitution does not, however, "require things which are different in fact or opinion to be treated in law as though they were the same," *ibid.* (quoting *Tigner* v. *Texas*, 310 U.S. 141, 147 (1940)), and a legislature must have some "latitude" in creating classifications that respond to perceived problems and "accommodate competing concerns both public and private," *ibid.*

In finding no rational basis for distinguishing between a patient's refusal of medical treatment and a physician's prescription of a lethal drug for the

purpose of helping a patient commit suicide, see Pet. App. 24a-25a, the court of appeals overlooked extremely important state interests offering substantial justification for this distinction. The gravity and magnitude of the harms that could accompany the prescription of lethal medication are such that a responsible, compassionate state legislator who took full account of the important liberty interest of a terminally ill person in avoiding protracted severe pain or suffering could still conclude that a prohibition on this practice was necessary to guard against those harms.

2. As we develop more fully in our amicus brief (at 16-24) in *Washington* v. *Glucksberg*, No. 96-110, at this point in our history, a state legislature could responsibly conclude that making physician assisted suicide available for some "would create widespread and unjustified risks for many others." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 135 (May 1994) (*Task Force Report*). Those dangers include the deaths of many persons who are not competent, not terminally ill, and not truly ready to die, but who are steered toward suicide by a confluence of forces, including a health care system that often undertreats patients' pain and depression; physicians who cannot or do not take the time to explore their patients' fears about the course of their illness and to reassure them of continued support; family members who are exhausted by the ordeal of a lingering illness; a mistaken diagnosis or prognosis; or the patients' own fears of being a "burden" to their loved ones or society.

3. Undoubtedly, some of these dangers also attend the decision to withhold or withdraw medical treat-

ment. In other respects, however, a legislature confronts weighty practical differences in terms of the dangers each practice poses to the lives and welfare of the State's citizens. Harms that arise from physician prescribed lethal medication often differ in kind or degree from those that result from patient refusal of medical treatment. Those harms include the erosion of the distinction between killing and letting die; the far more serious consequence of an erroneous diagnosis of a terminal illness; and the far greater number of persons whose lives could be shortened through error or undue influence. Also supporting the distinction between the two practices is the often invasive nature of life support.

a. The principal distinction between providing a patient lethal medication and allowing a patient to refuse treatment is the widely accepted distinction between killing and letting die. To let a patient die is to acknowledge the futility of further medical treatment and to let nature run its course. Death results from the underlying fatal pathology of the patient's disease or disorder, not from the independent action of the physician. Physician prescribed lethal medication, in contrast, provides its own fatal pathology. There is, in short, "a fundamental difference between what nature does to us and what we do to one another." Daniel Callahan, *The Troubled Dream of Life* 76 (1993). That intuitive distinction, which comports with our common experience, is reflected in state law and medical practice. See 96-110 Pet. App. A68 & n.77 (listing States that permit the withdrawal of life-sustaining treatment); *id.* at A135-A136 (listing States that prohibit assisted suicide); see also *Thor* v. *Superior Court*, 855 P.2d 375, 385 (Cal. 1993) ("[A] necessary distinction exists between a person suffering from a serious life-threatening disease or debilitating injury who rejects medical intervention that only prolongs but never cures the affliction and an individual who deliberately sets in motion a course of events aimed at his or her own demise and attempts to enlist the assistance of others."); *McKay* v. *Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) (recognizing a "substantial difference" between "non-interference with the natural consequences of [a patient's] condition" and a patient's "terminat[ing] his or her life by some deadly means either self-inflicted or through the agency of another"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("A death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient [or physician].").

Underlying this distinction are important ethical considerations about the physician's professional responsibility to do no harm. The medical profession recognizes ethical distinctions between discontinuing unwanted, futile treatments and "using the tools of medicine to cause a patient's death." Council on Ethical and Judicial Affairs, American Medical Ass'n, *Decisions Near the End of Life*, 267 J. Am. Med. Ass'n 2229, 2230-2231, 2233 (1992); see Brian McCormick, *Continued Opposition: House Refuses to Open Door on Physician-Assisted Suicide*, Am. Med. News, Dec. 20, 1993 at 7; Willard Gaylin, et al., *Doctors Must Not Kill*, 259 J. Am. Med. Ass'n 2139 (1988); Mildred Solomon, et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14, 17 (Jan. 1993). A State legitimately can assert an interest in preserving this boundary; allowing physicians to participate in suicide could erode public confidence in the profession

and undermine patients' trust in their doctors. See Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 824 (1994) (that few people "may find medical professionals willing and able to ratify and to assist in * * * [suicide] is easily outweighed by the distrust and acute ambivalence engendered in the majority by assigning such a disparate role to an unwilling profession"). The prohibition on assisting suicide erects an important psychological barrier for the physician who might be tempted to resort to a quick exit for the patient whose illness he cannot cure. Moreover, reasonable legislators could fear that legalizing assisted suicide "[c]ould have a subtle but widespread impact on society" by sending the message that society does not value each of its members. *Task Force Report* 101-102.

It is true that a patient's right to terminate his treatment allows him in some circumstances to enlist the assistance of a physician to exercise that right, for example, by removing a feeding tube. It also is true that the removal of a feeding tube requires greater physician involvement and greater bodily intrusion than what respondents seek here. But the distinction between killing and letting die rests on the underlying cause of the patient's death, not on the mere involvement of a physician. With the removal of the feeding tube, the cause of death (assuming the patient dies) is the underlying illness that robbed him of his ability to eat; the physician's removal of the feeding tube lets that illness run its course. With the provision of lethal medication, the physician provides the cause of the patient's death. While this distinction may not be satisfying in all respects, it is workable, and it is grounded in moral and ethical considerations that the State has an interest in preserving. Moreover, as we develop more fully in our amicus brief (at 22-24) in *Washington* v. *Glucksberg*, No. 96-110, permitting the prescription of lethal medication, but attempting to limit it to the terminally ill and to avoid euthanasia, presents equally problematic distinctions and far greater risks. See generally Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 6, 63-64 (1996) (Callahan & White); Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on* Roe, Casey, *and the Right to Die*, 44 Am. U. L. Rev. 803, 820-824 (1995); Timothy Quill, et al., *Care of the Hopelessly Ill—Proposed Clinical Criteria For Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380, 1381 (1992); 96-110 Pet. App. A100-A101 (Ninth Circuit, sitting en banc, acknowledging the difficulty of maintaining any distinction between physician–prescribed and physician–administered medication).

b. Also reinforcing the current distinction between physician assisted suicide and the refusal of medical treatment is the State's undeniable interest in preventing the death of persons who are erroneously diagnosed as terminally ill. Predicting a patient's life expectancy is difficult and uncertain. See, *e.g.*, Joanne Lynn, et al., *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 W. J. Med. 250, 251 (1995). "A surprising number of people have had the experience of being misinformed that they had a terminal illness." Richard A. Posner, *Aging and Old Age* 245 (1995). "[Physician] assisted suicide leave[s] no opportunity to recognize or correct a diagnosis that is negligently provided, or

provided competently, but proves incorrect over time." *Task Force Report* 131. By contrast, the termination of life-sustaining medical treatment for a person wrongly believed to be dependent on such treatment does not result in certain death. Karen Ann Quinlan, for example, lived for years after her life support was disconnected. See George J. Annas, *The "Right to Die" in America: Sloganeering from* Quinlan *and* Cruzan *to* Quill *and* Kevorkian, 34 Duq. L. Rev. 875, 881 n.13 (1996).

c. Refusal to permit physician assisted suicide may also be justified by the predictable difficulty of regulating and limiting such assistance, particularly when it could be offered to all terminally ill persons, or even all members of society. The privacy that appropriately cloaks the doctor-patient relationship could lead thoughtful legislators to conclude that "the nature of the doctor-patient relationship and of the medical procedures themselves renders them resistant to * * * 'clear criteria, rigorous procedures, and adequate safeguards.'" Callahan & White, 30 U. Rich. L. Rev. at 2 (quoting Franklin Miller, et al., *Regulating Physician-Assisted Suicide*, 331 New Eng. J. Med. 119, 120 (1994)). While permitting patients to decline life-sustaining treatment admittedly creates some of the same risks, those risks are limited to an identifiable, self-contained class of persons—those who cannot live without the treatment—many of whom are in hospitals or nursing homes, where their care may be supervised by others. See *Task Force Report* 74; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* 17-18 (Mar. 1983). A legislature reasonably could decide to entrust state regulators, professional organizations, and institutional review boards with the admittedly difficult task of regulating to avoid error and abuse with regard to this group of patients, without having sufficient confidence that they could perform the same task with regard to the vast number of patients who could seek physician assisted suicide.

d. The invasiveness of some compelled life-sustaining treatment presents another legitimate basis for allowing patients to decline it, even while prohibiting physician assisted suicide. As one commentator described it, to be forced to receive life-sustaining treatment "is in fact to be forced into a particular, all-consuming, totally dependent, and indeed rigidly standardized life: the life of one confined to a hospital bed, attached to medical machinery," with his body "so far expropriated from his own will, supposing that he seeks to die, that the most elemental acts of existence—such as breathing, digesting, and circulating blood—are forced upon him by an external agency." Jed Rubenfeld, *The Right to Privacy*, 102 Harv. L. Rev. 737, 795 (1989). To deny physician assistance in committing suicide is to foreclose one humane and certain route of escape from pain and suffering, but it does not subject a person to nearly the same degree of intrusion and restraint as requiring a person to submit to unwanted medical treatment.

Taken together, these public policy considerations provide substantial justification for prohibiting physician prescribed lethal medication while permitting patient refusal of medical treatment. The court of appeals therefore erred in concluding that the State's interests in preserving this distinction were "[n]one." Pet. App. 31a.

II. THE NEW YORK STATUTORY PROHIBITION OF ASSISTED SUICIDE SUFFICIENTLY REFLECTS A CONTEMPORARY LEGISLATIVE JUDGMENT

Similarly, Judge Calabresi erred in concluding that New York has made no contemporary assertion of the prohibition against assisted suicide. He argued that the statutes criminalizing assisted suicide are anachronisms "born in another age" when suicide itself was a crime and that the New York legislature has retained them through inertia, failing to make any actual, considered legislative judgment to continue those proscriptions or to articulate the state justifications for them. Pet. App. 38a, 57a. That view overlooks significant developments in New York law.

1. Suicide or attempted suicide has not been a crime in New York since 1919. Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193. In 1965, the New York legislature deleted the statutory declaration that suicide is a "grave public wrong." Act of July 20, 1965, ch. 1030, 1965 N.Y. Laws 1544 (codified at N.Y. Penal Law § 35.10(4) (McKinney 1987)). At that time, the legislature reasserted the criminal prohibitions against intentionally causing or aiding a suicide or attempted suicide—the statutory provisions at issue here. See N.Y. Penal Law §§ 120.30, 125.15(3) (McKinney 1987). That reflects, at the very least, not inertia, but rather a legislative judgment to continue the criminal prohibition against assisting suicide while deleting condemnation of the suicide itself.

2. Since 1965, the New York legislature has adopted legislation giving force to a patient's common law right to refuse medical treatment, but preserving the distinction between refusing unwanted medical treatment on the one hand and assisted suicide or euthanasia on the other. In 1987, the legislature enacted a statute permitting a competent adult to create an order not to resuscitate, or administer cardiopulmonary resuscitation (CPR), in the event that the person suffered cardiac or respiratory arrest. Act of Aug. 7, 1987, ch. 818, § 1, 1987 N.Y. Laws 1526 (codified as amended at N.Y. Pub. Health Law §§ 2960-2979 (McKinney 1993 & Supp. 1996)). The legislature adopted that measure in response to a 1986 report and recommendation by the New York State Task Force on Life and the Law. See *Do Not Resuscitate Orders: The Proposed Legislation and Report of the New York State Task Force on Life and the Law* (Apr. 1986). After acknowledging distinctions between the common law right to refuse treatment (to which the legislature was giving effect) and suicide (which the State has an interest in preventing), the Task Force noted that the State's interest in preserving life gave way in the case of orders not to resuscitate primarily because of the highly invasive nature of CPR. *Id.* at 15.

In 1990, the legislature sought further to protect the patient's right to decline unwanted treatment by allowing persons to direct the withholding of life-sustaining treatment through health care proxies and the appointment of health care agents. Act of July 22, 1990, ch. 752, § 2, 1990 N.Y. Laws 1538 (codified as amended at N.Y. Pub. Health Law § 2982(1) (McKinney 1993)). The legislature again acted at the recommendation of the Task Force. See New York State Task Force on Life and the Law, *Life-Sustaining Treatment: Making Decisions and Appointing a Health Care Agent* (July 1987). The Task Force's report accompanying its proposed legislation included

a thoughtful discussion of the need to preserve the distinction between "killing" and "letting die." See *id.* at 36-42. The legislature went a step further, incorporating into the statute an express caveat preserving that distinction:

> This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law.

N.Y. Pub. Health Law § 2989(3) (McKinney 1993). Thus, the legislature, in the context of respecting patients' liberty interests in determining the course of their medical treatment, consciously reinforced the line between the permissible withdrawal of life-sustaining treatment and the prohibited assistance of suicide. That recent legislative reaffirmance of this well-established and widely-accepted line convincingly answers Judge Calabresi's assertion that the distinction has endured merely through legislative inertia.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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October Term, 1996

DENNIS C. VACCO, ET AL.,

Petitioners,

v.

TIMOTHY E. QUILL, ET AL.,

Respondents.

On Writ Of Certiorari
To The United States Court Of Appeals
For The Second Circuit

BRIEF OF THE AMERICAN LIFE LEAGUE, INC., AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

INTEREST OF AMICUS 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. IT VIOLATES THE EQUAL PROTECTION GUARANTEE OF THE FOURTEENTH AMENDMENT FOR A STATE TO PROTECT INNOCENT, NON-AGGRESSOR PERSONS IN GENERAL BY PROHIBITING THEIR INTENTIONAL KILLING AS HOMICIDE, AND THEN TO CARVE OUT AN EXCEPTION TO THAT PROTECTION SO AS TO ALLOW SOME SUCH PERSONS TO BE INTENTIONALLY KILLED. 4

II. IN DECIDING THE *QUILL* CASE, THIS COURT SHOULD RECONSIDER *CRUZAN*, SINCE BOTH DECISIONS, AS WELL AS *COMPASSION IN DYING*, ALLOW THE INTENTIONAL KILLING OF INNOCENT, NON-AGGRESSOR PERSONS. 8

III. WHEN A STATE EXCLUDES ANY CLASS OF INNOCENT, NON-AGGRESSOR PERSONS FROM ITS GENERAL PROHIBITION AGAINST INTENTIONAL KILLING, IT STEPS UPON A SLIPPERY SLOPE LEADING PREDICTABLY TO THE INVOLUNTARY KILLING OF THE UNWANTED. 11

IV. THE LAW CAN PROTECT PATIENTS AGAINST INTENTIONAL KILLING WITHOUT INTERFERING WITH PROPER MEDICAL DECISIONS. 18

CONCLUSION 20

TABLE OF AUTHORITIES

Page

CASES

Blackburn v. State, 23 Ohio St. 146 (1873) 5

Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986) 9

Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir.) (en banc), *cert. granted, Washington v. Glucksberg*, 117 S. Ct. 37 (1996) ..... *passim*

Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990) ..... *passim*

Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) 12

Furman v. Georgia, 408 U.S. 238 (1972) 5, 7

Quill v. Vacco, 80 F.3d 716 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996) ..... *passim*

Roe v. Wade, 410 U.S. 113 (1973) 4

State v. Williams, 484 P.2d 1167 (Wash. Ct. App. 1971) 10

Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986) 4

CONSTITUTIONAL PROVISION

U.S. Const. amend. XIV, § 1 ..... *passim*

TABLE OF AUTHORITIES – Continued

Page

OTHER AUTHORITIES

Alexander, *Medical Science Under Dictatorship*, 241 New Eng. J. Med. 39 (1949) 12

Binding & Hoche, *The Release of the Destruction of Life Devoid of Value* (Robert L. Sassone, 1975) (1920) 13, 14

Cong. Globe, 35th Cong., 1st Sess. App. 65-66 (1858) 6

Cong. Globe, 39th Cong., 1st Sess. 74 (1865) 6

Cong. Globe, 40th Cong., 1st Sess. 542 (1867) 7

3 Cong. Rec. 1794 (1875) 7

Kamisar, *When Is There A Constitutional "Right to Die"? When Is There* No *Constitutional "Right to Live"?* 25 Ga. L. Rev. 1203 (1991) 12

Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide – And Why These Reasons Are Not Convincing*, 12 Issues L. & Med. 113 (1996) 17

LaFave & Scott, *Criminal Law* (1972) 11

Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1 (1985) 15

Roberts, *Next, The Regulated Life Span?*, Wash. Times, April 10, 1990, at F3 14

Sprung, *Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments*, 263 J. Am. Med. Ass'n 2211 (1990) 14

Stanton, *The New Untermenschen*, Hum. Life Rev. Fall 1985, at 77 12

INTEREST OF AMICUS*

Amicus curiae, American Life League, Inc., is a District of Columbia corporation, with its office in Stafford, Virginia, recognized under 26 USC § 501(c)(3) as a tax-exempt organization. The *Amicus* is a social welfare and educational organization, incorporated in 1981, with some 300,000 active supporting families across the country.

The *Amicus* researches and publishes a magazine, newsletters, brochures and other material relating to the human rights of persons born and preborn; sponsors, and participates in, symposia and other public and invitational means of discussion and education; monitors, and reports upon, pertinent state and federal administrative, legislative, and judicial developments; and otherwise seeks to fulfill the mandate of its Articles of Incorporation and the concerns of its supporters. Its professional and volunteer staff includes those experienced in the fields of medicine, science, public policy, theology and law, and other persons who are, or who have become, cognizant in areas of factual and interpretive knowledge as to biological, theological, philosophic, legal, political and economic aspects of the rights of persons born and preborn.

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* The parties to the present case have consented to the filing of this brief; letters granting consent are being submitted with this brief.

SUMMARY OF ARGUMENT

This case presents a challenge to various sections of the New York Penal Law making it a crime to aid a person in committing suicide or attempting to commit suicide. The lower court struck down the New York laws as violative of the United States Constitution because these laws lack any rational basis and violate the equal protection clause of the fourteenth amendment. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996). The lower court held that the New York laws do not treat similarly circumstanced persons alike in that those in the final stages of terminal illness who are on life support systems are allowed to be killed by the removal of such systems, but those who are similarly situated, except for previous attachment to the life support systems, are not allowed to be killed by self-administering prescribed drugs. Further, the court held that New York does not have any apparent interest in requiring the prolongation of a life that is all but ended.

The lower court's equal protection analysis is incorrect. Contrary to the lower court's decision in *Quill*, it violates the equal protection guarantee of the fourteenth amendment for a state to protect innocent non-aggressor persons in general by prohibiting their intentional killing as homicide, and then to carve out an exception to that protection so as to allow some such persons to be intentionally killed. The equal protection guarantee demands that "No state shall . . . deny to *any person* the equal protection of the laws." U.S. Const. XIV amend., § 1 (emphasis added).

In addition to deciding this case, this court should reconsider its decision in *Cruzan v. Director, Missouri*

Department of Health, 497 U.S. 261 (1990), since both decisions, as well as *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc), allow the intentional killing of innocent, non-aggressor persons. By prohibiting the intentional killing of innocent non-aggressor persons in general, a state violates the equal protection clause to carve out an exception to that protection so as to allow some such persons to be intentionally killed. Furthermore, when a state excludes any class of innocent non-aggressor persons from its general prohibition against intentional killing, it steps upon a slippery slope leading predictably to the involuntary killing of the unwanted.

It is possible, however, for the law to protect patients against intentional killing without interfering with proper medical decisions. There comes a time when a person has done all that is reasonably required of him to preserve and prolong his life, nature should be allowed to take its course, and the proper judgments of physicians and family should be respected. In this context, a person should be allowed to die a natural and dignified death. Such cases are not now before this court. Rather, since the situations in *Quill*, *Compassion in Dying*, and *Cruzan* all involve the intentional killing of innocent non-aggressor persons, this court should reject the holding and reasoning in *Quill*, as well as of *Compassion in Dying*, and should reconsider its holding in *Cruzan*. This court ought to reaffirm the basic entitlement to equal protection against intentional killing.

ARGUMENT

I. IT VIOLATES THE EQUAL PROTECTION GUARANTEE OF THE FOURTEENTH AMENDMENT FOR A STATE TO PROTECT INNOCENT, NON-AGGRESSOR PERSONS IN GENERAL BY PROHIBITING THEIR INTENTIONAL KILLING AS HOMICIDE, AND THEN TO CARVE OUT AN EXCEPTION TO THAT PROTECTION SO AS TO ALLOW SOME SUCH PERSONS TO BE INTENTIONALLY KILLED.

The basic issue presented in this brief was capsulized by Justice Stevens in *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 779 (1986) (Stevens, J., concurring), where he stated that "the permissibility of terminating the life of a person could scarcely be left to the will of the state legislatures." *See also Roe v. Wade*, 410 U.S. 113, 157 n.54 (1973). In *Roe v. Wade*, the court conceded that if "the fetus is a 'person' within the language and meaning of the fourteenth amendment . . . the appellant's case, of course, collapses." *Id.* at 156. The governing principle here is that a fourteenth amendment "person" does not hold his life subject to the will of the legislature as to whether another shall be legally permitted to kill him.[1]

The fourteenth amendment provides: "No state shall . . . deny to *any person* the equal protection of the laws."

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[1] *Roe v. Wade* held that the preborn child is not a fourteenth amendment "person," whether or not he is a human being. *Roe's* recognition of the right to kill the preborn nonperson has an obvious bearing upon the subsequent allowance by courts of intentional killing in the "right-to-die" context. However, an examination of *Roe* itself is beyond the scope of this brief.

U.S. Const. XIV amend., § 1 (emphasis added). In *Cruzan* and *Quill*, as well as *Compassion in Dying*, the patients involved are all "persons" within the meaning of the fourteenth amendment. They are all innocent non-aggressors. Clearly, if the fourteenth amendment guarantee of equal protection means anything, it must mean that such persons cannot be excluded from the protection of state homicide laws by permitting them to be intentionally killed by others in any situation. Yet, the courts' decisions in all three cases allowed precisely that.

" 'The life of those to whom life has become a burden – of those who are hopelessly diseased or fatally wounded – nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment and anxious to continue to live.' " *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (quoting *Blackburn v. State*, 23 Ohio St. 146, 163 (1873)). Furthermore, " 'The lives of all are equally under the protection of the law, and under that protection to their last moment. . . . [Assisted suicide] is declared by the law to be murder, irrespective of the wishes or the condition of the party to whom the poison is administered. . . . ' " *Id.* (quoting *Blackburn*, 23 Ohio St. at 163). The right to life is the most basic right, since death forecloses "the right to have rights." *See Furman v. Georgia*, 408 U.S. 238, 290 (1972) (Brennan, J., concurring). As Representative Joshua R. Giddings put it:

> Our fathers, recognizing God as the author of human life, proclaimed it a "self-evident" truth that every human being holds from the Creator an inalienable right to live . . . .

> . . . If this right be denied, no other can be acknowledged. If there be exceptions to this central, this universal proposition, that *all men*, without respect to complexion *or condition*, hold from the Creator the right to live, who shall determine what portion of the community shall be slain? And who may perpetrate the murders?

Cong. Globe, 35th Cong., 1st Sess. App. 65-66 (1858) (second emphasis added).

Representative Thaddeus Stevens summarized the principle:

> This is man's Government; the Government of all men alike; not that all men will have equal power and sway within it. Accidental circumstances, natural and acquired endowment and ability, will vary with fortunes. But equal rights to all the privileges of Government is innate in every immortal being, no matter what the shape or color of the tabernacle which it inhabits.

Cong. Globe, 39th Cong., 1st Sess. 74 (1865).

Similarly, Representative John A. Bingham, author of section one of the fourteenth amendment, declared, with reference to the fifth amendment, the principle he viewed as fundamental:

> [T]he Constitution of the United States . . . declared that "no person shall be deprived of life, liberty, or property without due process of law." By that great law of ours it is not inquired whether a man is "free" by the laws of England; it is only to be inquired *is he a man*, and therefore free by the law of that creative energy which breathed into his nostrils the breath of

> life, and he became a living soul, endowed with the rights of life and liberty. . . .
>
> Before that great law *the only question to be asked of a creature claiming its protection is this: Is he a man?* Every man is entitled to the protection of American law, because its divine spirit of equality declares that all men are created equal.

Cong. Globe, 40th Cong., 1st Sess. 542 (1867) (emphasis added). Senator Allen G. Thurman stated that a state may not deny equal protection to "any person" in the jurisdiction, "be he sane or be he insane, be he old or be he young, be he innocent or be he criminal, be he learned or be he ignorant." 3 Cong. Rec. 1794 (1875). And as Justice Brennan put it in another context,

> At bottom, the battle has been waged on moral grounds. The country has debated whether a society for which the dignity of the individual is the supreme value can, without a fundamental inconsistency, follow the practice of deliberately putting some of its members to death.

Furman, 408 U.S. at 296 (Brennan, J., concurring).

In summary, since the right to life is the indispensable right, it violates the equal protection of the laws for a state to deny to some innocent non-aggressor persons the protection against intentional deprivation of that right which it provides to such persons in general.

II. IN DECIDING THE *QUILL* CASE, THIS COURT SHOULD RECONSIDER *CRUZAN*, SINCE BOTH DECISIONS, AS WELL AS *COMPASSION IN DYING*, ALLOW THE INTENTIONAL KILLING OF INNOCENT, NON-AGGRESSOR PERSONS.

It is essential to note, first, what these cases do *not* involve. They do not involve the difficult decisions as to the withholding or withdrawal of medical treatment that is arguably burdensome, dangerous, extraordinary or disproportionate to the expected outcome. The law, which is a blunt instrument, can have only a limited role in such cases. Such cases are not now before this court. Rather, our concern is with cases involving actions by third persons taken with the specific intention of causing the death of the patient in question. *Cruzan* involved the withdrawal of food and water provided by tube, the provision of which was not burdensome, dangerous, extraordinary, or disproportionate to the expected outcome, from an incompetent patient. The nutrition and hydration were withdrawn with the specific intent of causing Nancy Cruzan's death with the purpose of carrying out her own desire to have them withdrawn and to die. In *Quill* and *Compassion in Dying*, the courts approved the administration of lethal agents with the same intention and purpose.

The distinction between passive and active killing, as noted by Justice Scalia in his concurrence in *Cruzan* is not helpful. *Cruzan*, 497 U.S. at 296-97 (Scalia, J., concurring). Starving a person to death, as the "caregivers" of Nancy Cruzan did to her, is no different from putting a gun to her temple and squeezing the trigger. As a matter of fact,

the latter method is probably less painful to the victim.[2] If Nancy Cruzan had miraculously sat up in her hospital bed and handed a gun to her "caregiver" and the "caregiver" killed Nancy, there would have been a trial for homicide. The fact that the "caregivers" chose to starve Nancy to death should be of no consequence in the eyes of the law. Courts have upheld convictions of parents for statutory manslaughter for negligently failing to supply their child with necessary medical attention which results

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[2] In a note to his opinion in *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 641, n.2 (Mass. 1986) (Lynch, J., dissenting), Justice Lynch recounted the physical hardship which the evidence in the case showed to be normally associated with starvation and dehydration:

> Removal of the G. tube would likely create various effects from the lack of hydration and nutrition, leading ultimately to death. Brophy's mouth would dry out and become caked or coated with thick material. His lips would become parched and cracked. His tongue would swell, and might crack. His eyes would recede back into their orbits and his cheeks would become hollow. The lining of his nose might crack and cause his nose to bleed. His skin would hang loose on his body and become dry and scaly. His urine would become highly concentrated, leading to burning of the bladder. The lining of his stomach would dry out and he would experience dry heaves and vomiting. His body temperature would become very high. His brain cells would dry out, causing convulsions. His respiratory tract would dry out, and the thick secretions that would result could plug his lungs and cause death. At some point, within five days to three weeks his major organs, including his lungs, heart, and brain, would give out and he would die.

Id.

in the death of the child. *State v. Williams*, 484 P.2d 1167 (Wash. Ct. App. 1971). Simply put, *Cruzan*, *Quill*, and *Compassion in Dying* are all cases dealing with the intentional killing of an innocent person who cannot in any way be described as an aggressor. In the assisted suicide cases, whether the doctor feeds the patient the poison or prescribes it, the intent of his act is to kill the patient. Some may attempt to distinguish cases where the victim has been declared "terminally ill." However, the attempt to make that distinction reinforces our equal protection argument. The law should not provide lesser protection to an innocent person, with respect to the indispensable right to life, merely because he or she has been defined as terminally ill. To do so is a violation of equal protection and therefore unconstitutional.

When a state protects innocent, non-aggressor persons in general by forbidding them to be intentionally killed by another, it would deny equal protection of the law for the state to exclude from that protection some such persons because they are terminally ill or because they have asked to be killed. *Cruzan*, *Quill*, and *Compassion in Dying* do not involve the question of whether a competent person has a constitutional right to commit suicide by his own unassisted hand. Apart from the incongruity that would be involved in a state trying to impose a criminal penalty on a person who successfully kills himself by his own hand, the state clearly has constitutional authority to forbid a person to attempt suicide by his own hand. *See Cruzan*, 497 U.S. at 298-300 (Scalia, J., concurring). Otherwise, one would have to affirm a constitutional right to alienate the unalienable right to life. However, the limited issue involved in *Cruzan*, *Quill*, and

Compassion in Dying is the question of whether the state may rightly withdraw criminal sanctions from a person who intentionally kills another because the victim has consented to his own homicide.

> Generally, it may be said that consent by the victim is not a defense in a criminal prosecution. The explanation most commonly given for this rule is that a criminal offense is a wrong affecting the general public, at least indirectly, and consequently cannot be licensed by the individual directly harmed. Thus, it is no defense to a charge of murder that the victim, upon learning of the defendant's homicidal intentions, furnished the defendant with the gun and ammunition.

Wayne R. LaFave & Austin W. Scott, Jr., *Criminal Law* 408 (1972) (footnotes omitted). In such cases, it would violate the equal protection clause for the state to exclude such persons from the protection of the general prohibition against homicide. Therefore, this court should not only reverse the judgment in *Quill*, and also in *Compassion in Dying*, but it should also reconsider its decision in *Cruzan*.

III. WHEN A STATE EXCLUDES ANY CLASS OF INNOCENT, NON-AGGRESSOR PERSONS FROM ITS GENERAL PROHIBITION AGAINST INTENTIONAL KILLING, IT STEPS UPON A SLIPPERY SLOPE LEADING PREDICTABLY TO THE INVOLUNTARY KILLING OF THE UNWANTED.

For a state to allow the intentional killing of certain innocent human beings is ultimately to subject the value of life to utilitarian considerations and to deny the very

humanity and dignity of the human person.[3] The slippery slope arguments have been made elsewhere,[4] and the

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[3] The Missouri State Supreme Court in *Cruzan v. Harmon*, 760 S.W.2d 408, 422 (Mo. 1988), *aff'd sub nom. Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990), observed that the argument "that Nancy will not recover, is but a thinly veiled statement that her life in its present form is not *worth living*. Yet a diminished quality of life does not support a decision to cause death." (emphasis added).

[4] *See* Yale Kamisar, *When Is There A Constitutional "Right to Die"? When Is There* No *Constitutional "Right to Live"?*, 25 Ga. L. Rev. 1203, 1206 (1991) (arguing that in the euthanasia context "[w]e have *moved down* the slippery slope a considerable distance; we have *seen* the slippery slope"); Leo Alexander, M.D., *Medical Science Under Dictatorship*, 241 New Eng. J. Med. 39 (1949). Dr. Alexander observed,

> Whatever proportions these crimes [of the Nazi euthanasia program] finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged . . . . But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the non-rehabilitable sick.

Id.; see also Joseph R. Stanton, M.D., *The New Untermenschem*, Hum. Life Rev., Fall 1985, at 77, 82 (noting that Dr. Alexander, shortly before his death, commented in 1984 on the situation in the United States: "It is much like Germany in the 20's and 30's – the barriers against killing are being removed").

decisions in *Quill* and *Compassion in Dying* confirm those apprehensions.

One can discern in these and other "right-to-die" cases a path leading toward involuntary, enforced euthanasia. The decisions and rhetoric in *Cruzan*, *Quill*, and *Compassion in Dying* bring to mind the arguments for euthanasia made in 1920 by Dr. Karl Binding and Dr. Alfred Hoche in *The Release of the Destruction of Life Devoid of Value*. Doctors Binding and Hoche wrote:

> By death with dignity, we don't mean only the right to death with dignity, but much more, the legally acknowledged right to the complete relief of an unbearable life. . . .
>
> Realizing that there is indeed human life whose continuation is of no interest to any reasonably thinking person, then it [sic] up to the legislature to ask this fateful question: "Is it our duty to continually defend this unsocial life by giving it full protection of the law or is it our duty to release it for euthanasia?" You could also pose this question from a legal point of view: Shall we prefer to see the continued support for this kind of life as an example of the sacredness of life or shall we consider the legalization of the mercy killing, so relieving for all those involved, as the smaller evil. . . .
>
> There is no point of view, not legal, social, moral nor religious which presents a good reason for failure to legalize the euthanasia of those persons desperately desiring death with dignity by those who are apt to do so. I consider this release or legalization a simple duty of justified compassion. We often apply compassion to various cases.

Karl Binding & Alfred Hoche, *The Release of the Destruction of Life Devoid of Value* 14-20 (Robert L. Sassone, 1975) (1920).

In the aftermath of *Cruzan*, *Quill*, and *Compassion in Dying*, how long will it be before some court will decide that the decision of an elderly, infirm person not to accept assisted suicide is evidence that he is legally incompetent to make such a decision – for is it not wholly irrational for a person with such a low quality of life to want to live? So therefore the decision must be made for him, for his own good of course. Significantly, arguments are currently made for the rationing of health care based on "fixed categories of patients."[5] And added pressures from the monitoring of physician's decisions by insurance companies, and the rising costs of Social Security and Medicare are moving society toward the adoption of a "regulated life span" with the prospect of enforced euthanasia.[6]

The legalization of intentional killing involved in *Cruzan*, *Quill*, and *Compassion in Dying* will predictably result in unacceptable consequences; for example, as noted by Thomas J. Marzen, et al., "if the 'right to die' recognized in present case law were deemed to encompass a 'right to suicide,' then suicide by substituted judgment – constitutionally sanctioned, active, involuntary euthanasia – of incompetent persons would be a logical

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[5] Charles L. Sprung, M.D., J.D., *Changing Attitudes and Practices in Forgoing Life-Sustaining Treatments*, 263 J. Am. Med. Ass'n 2211, 2214 (1990).

[6] Paul Craig Roberts, *Next, The Regulated Life Span?*, Wash. Times, April 10, 1990, at F3.

consequence." Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 102 (1985). As Marzen notes:

> Any attempt to limit this "right to suicide" to certain persons or circumstances, for example to persons who are terminally ill or elderly, would conflict with the "freedom of choice" or privacy theory that is advanced to assert the existence of such a "right" in the first place. . . .
>
> The young woman tragically disappointed in love, the middle-aged man who has lost his family and whose career has been destroyed, the depressed teen, and the person of any age who has been severely disabled, all might well believe that they ought to be able to exercise this "right" with the same freedom as the person who is terminally ill or older. . . . [T]here is nothing in the Constitution that would limit the existence of a right it acknowledges in such a selective and arbitrary fashion [as to apply only to terminally ill or elderly persons].

Id. at 102-03.

Further, as Yale Kamisar notes:

> There is another reason I very much doubt that the right to assisted suicide could or would be limited for very long to persons who are terminally ill – the force of reasoning contained in the analysis of [*Quill* and *Compassion in Dying*] that handed down the right to die decisions I discussed earlier. Both the Second and Ninth Circuits seemed to agree with those proponents of assisted suicide who maintain there is no principled difference in terms of constitutional doctrine and precedent between the alleged right to

assisted suicide and the established right to terminate life support. The problem is that the right to reject life-sustaining treatment has not been limited to terminally ill people.

One need only recall the *Elizabeth Bouvia* case, which arose a decade ago. At the time of the litigation, Ms. Bouvia, a young woman afflicted with severe cerebral palsy, had a long life expectancy. Nor was she unconscious or mentally impaired. Indeed, the court described her as both "intelligent" and "alert." Nevertheless, she was granted the relief she sought – the right to remove a tube keeping her alive against her wishes.

To be sure, neither the *Bouvia* case nor other cases upholding the right of nonterminally ill persons to reject life-sustaining treatment were decided by the U.S. Supreme Court. But *Bouvia* and these other cases have been well received by bioethicists and medicolegal commentators. . . .

If the Second Circuit is right about terminally ill patients being "similarly situated" *whether or not* they are on life support, does it not follow that patients suffering from the same *nonterminal* illness are also "similarly situated," regardless of whether they are on life support? If the Second Circuit's equal protection analysis is sound, how can we prevent persons suffering serious but not terminal illnesses from enlisting the aid of another to die by suicide when patients with the same nonterminal illnesses *who are on life support systems* may hasten their deaths by directing the removal of such systems? Are not the "similarly circumstanced"

group of nonterminally ill patients *off* life support systems being denied equal protection?

Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide – And Why These Reasons Are Not Convincing*, 12 Issues in L. & Med. 113, 129-30 (1996).

For the law to recognize a right to assisted suicide for those defined as "terminally ill" would invite the development of loose criteria defining those who fall within this category. Despite the court's contention in *Quill*,[7] no doctor can say with certainty how long a person may live. Taken to its logical extreme, in the end, are we not all "terminally ill"?

There is reason to expect that the creation of a fundamental right to assisted suicide, or the creation of a right to assisted suicide based on equal protection principles, will result in constitutionally sanctioned active, involuntary euthanasia. While Dr. Alexander observed in 1984 that the situation in the United States regarding the value of human life was approaching that of Germany in the 20's and 30's, *see supra* note 4, this court today has the opportunity to reconstruct some of the fallen barriers against the intentional killing of innocent human life. As a result, this court should reaffirm the fundamental precept of the equal protection clause and require state laws that generally prohibit homicide to protect all innocent non-aggressor persons. No innocent, non-aggressor can be rightfully exempted from the protection of state homicide laws on account of a utilitarian notion of human life.

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[7] See the discussion regarding the definition of "terminally ill." *Quill*, 80 F.3d at 731.

Therefore, this court ought to reconsider *Cruzan* in light of these principles and in the context of *Quill* and *Compassion in Dying*.

IV. THE LAW CAN PROTECT PATIENTS AGAINST INTENTIONAL KILLING WITHOUT INTERFERING WITH PROPER MEDICAL DECISIONS.

A sound determination of "right-to-die" cases is difficult, but not impossible. It can be difficult to distinguish legitimate withholding or withdrawal of medical treatment, including termination of the administration of food and water that no longer sustains the life of a patient near death, from actions which are homicidal in intent. The law should not require that excessive treatment be given to impede the act of dying. There comes a time when a person has done all that is reasonably required of him to preserve and prolong his life, nature should be allowed to take its course, and the proper judgments of physicians and family should be respected. In this context, a person should be allowed to die a natural and dignified death.

In what situations, then, should the law interfere? We can safely enumerate two. First, it should do so in cases involving the circumstances presented in *Quill* and *Compassion in Dying*. These cases should be considered unlawful *per se* since they always involve the intentional killing of an innocent non-aggressor person. The fact that the patient is terminally ill is of no consequence. For example, if the physician were to shoot and kill a terminally ill patient only moments before the patient's death, the physician could be convicted for an unlawful homicide. As argued in this brief, where state law forbids the

intentional killing of innocent non-aggressor persons in general, a state may not carve out an exception for some such persons, such as those who are terminally ill or even imminently dying; to do so would violate the equal protection clause. Therefore, assisted suicide must be unlawful per se because it involves the intentional killing of innocent non-aggressor persons; it is of no consequence that the patient requests to be killed.

Second, the law should forbid the *Cruzan*-type case because it too involves unlawful, intentional killing. Three factors characterize such cases and help to illustrate this point:

1. The patient in the *Cruzan*-type case is *not dying or near death*. Nancy Cruzan, for example, had a life expectancy of 30 years;

2. These type cases *do not involve the withdrawal of medical treatment, including food and water provided by tube, that is burdensome, dangerous, extraordinary, or disproportionate to the expected outcome*. In *Cruzan*, the administration of food and water by tube was effective in sustaining Nancy Cruzan's life. It was therefore not useless even though it obviously would not correct her underlying condition; and

3. The action in question, the withdrawal of medical treatment, was taken with the *specific intent to cause the death* of the patient. The motive or purpose of the action may have been to relieve the patient of life considered burdensome or useless, but the clear and specific intent was to achieve that purpose by means of intentionally killing the patient. A permissible intention, on the other hand, would be to ease the

excessive pain *caused by the medical treatment itself.*

In these two classes of cases, assisted suicide and the *Cruzan*-type case, the law must protect the potential victims by providing to them the equal protection of the homicide laws. Other types of cases might be conjectured but they are not before the court today.

In summary, it is impermissible for a state to carve out an exception to the general protection of its homicide laws merely because a patient is considered terminally ill or because the patient's life is considered burdensome or useless, even when the patient has consented to be killed. Since the situations in *Quill, Compassion in Dying,* and *Cruzan* all involve the intentional killing of innocent non-aggressor persons, this court should reject the holding and reasoning of *Quill,* as well as of *Compassion in Dying,* and should reconsider its holding in *Cruzan.*

CONCLUSION

As Circuit Judge Calabresi noted in *Quill,* there is "no sign that . . . [a] 'culture of life' reigns in New York State – quite the contrary." *Quill,* 80 F.3d at 740 (Calabresi, J., concurring). This court, however, ought to reaffirm that the U.S. Constitution promotes the "culture of life" and rejects the "culture of death." This court ought to overrule *Quill,* and also *Compassion in Dying,* and ought to reconsider its decision in *Cruzan* so as to reaffirm the

basic entitlement to equal protection against intentional killing.

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No.95-1858

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1995

DENNIS C. VACCO, et al.,
Petitioners,
v.
TIMOTHY E. QUILL, et al.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF AMICI CURIAE OF NOT DEAD YET and AMERICAN DISABLED FOR ATTENDANT PROGRAMS TODAY IN SUPPORT OF PETITIONERS

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44 pp

TABLE OF CONTENTS

		PAGE
Table of Authorities		(iii)
Interest of Amici Curiae		1
Summary of Argument		3
Argument		4
I.	The Creation Of A Right To Assisted Suicide For A Class Of Individuals Based On Health Status Or Disability Is A Lethal Form Of Discrimination Which Violates The ADA	4
	A. People With Disabilities, With Either Terminal Or Nonterminal Health Impairments, Are The Class Of People Affected By The Proposed Right To Assisted Suicide	4
	B. Denying People With Disabilities The State Benefit Of Suicide Prevention And The Enforcement Of Abuse, Neglect, And Homicide Laws Violates The ADA	14
II.	Adequate Safeguards Cannot Be Adopted To Protect People With Disabilities From Assisted Suicide Abuse And Therefore An Unequivocal Rule Must Be Established Prohibiting Assisted Suicide	21
	A. Any Purported Limitation Of The Right To Assisted Suicide To Terminally Ill Persons Will Not Protect People With Severe Disabilities	21

B. Any Purported Limitation Of A Right To Assisted Suicide Only In Cases Of "Voluntary" Requests Will Not Protect People With Disabilities From Abuse 24

III. If This Court Finds That A Constitutional Or Statutory Right To Assisted Suicide May Exist, Then This Right Should Be Afforded To Everyone Without Discriminating Against People Because Of Health Or Disability Status 28

Conclusion 30

TABLE OF AUTHORITIES

PAGE

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42 U.S.C. § 12101 et seq. passim
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PAGE

28 C.F.R. §35.130(b) 18

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No. 95-1858

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1995

DENNIS C. VACCO, et al.,
Petitioners,
v.
TIMOTHY E. QUILL, et al.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

AMICI CURIAE BRIEF OF NOT DEAD YET and AMERICAN DISABLED FOR ATTENDANT PROGRAMS TODAY IN SUPPORT OF PETITIONERS

INTERESTS OF AMICI CURIAE

Amici are two national organizations composed primarily of persons with disabilities, including persons with spina bifida, cerebral palsy, muscular dystrophy, spinal cord injuries, multiple sclerosis, quadriplegia, paraplegia, head and brain injuries, polio, amyotrophic lateral sclerosis, as well as many other disabilities. Most of these

persons use assistive devices, including motorized and manual wheelchairs, ventilators, and personal assistance services for meeting their personal hygiene needs, transferring from bed to wheelchair and preparing food.

NOT DEAD YET is a national organization of people with severe disabilities who oppose the legalization of assisted suicide because it singles out people with significant health impairments for assistance to die, denying them the equal protection of laws and medical practice standards automatically applied to healthy individuals who are suicidal. Since 1985, individuals who are now Not Dead Yet members have participated actively in numerous states in the formulation of public policy concerning the so-called "right to die," have written numerous published articles on the issue, and were invited and testified recently before the Constitution Subcommittee of the Judiciary Committee of the U.S. House of Representatives on assisted suicide.

AMERICAN DISABLED FOR ATTENDANT PROGRAMS TODAY (ADAPT) is a national organization, most of whose members have severe disabilities and have been institutionalized in nursing facilities and other public institutions solely because they have disabilities. ADAPT has a long history and record of enforcing the civil rights of people with disabilities and was one of the key organizations

that participated in the political and legislative process that resulted in the passage in 1990 of the Americans With Disabilities Act, 42 U.S.C. § 12101 et seq., ("ADA"). It was the plaintiff in the case ADAPT v. Skinner, U.S. Department of Transportation, 867 F.2d 1471, 881 F.2d 1184 (3d Cir. 1989). [1]

SUMMARY OF ARGUMENT

Discrimination against people with severe disabilities pervades our society. Assisted suicide is the most lethal form of such discrimination. Applied only to people with significant health impairments, assisted suicide is the ultimate expression of society's fear and revulsion regarding disability. Health status becomes the basis of a double standard in which people with disabilities, a "discrete and insular minority," 42 U.S.C. § 12101(a)(7), are discriminatorily denied the protection of suicide prevention laws, medical practice standards, and statutes prohibiting abuse, neglect and homicide that nondisabled persons receive. This double standard based on health status violates the ADA.

Given the pervasive prejudice against and social devaluation of people with severe disabilities and the absence of adequate health

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[1] All parties have consented in writing to filing of this brief. Copies of the written consents are on file with the Clerk of the Supreme Court.

care and appropriate supportive services, safeguards cannot be established to prevent abuses resulting in the wrongful death of numerous disabled persons, old and young.

If, however, this Court were to uphold a constitutional right to assisted suicide or authorize its legalization by states, such provisions should apply to everyone -- regardless of health status or disability -- on a nondiscriminatory basis.

ARGUMENT

I. The Creation Of A Right To Assisted Suicide For A Class Of Individuals Based On Health Status Or Disability Is A Lethal Form Of Discrimination Which Violates The ADA.

A. People With Disabilities, With Either Terminal Or Nonterminal Health Impairments, Are The Class Of People Affected By The Proposed Right To Assisted Suicide.

The outcome of this case potentially threatens the lives and well-being of a significant number of the 23,588,000 noninstitutionalized people in the United States who have severe disabilities. [2] They comprise 12.1 percent of the total population, 15 years old and over in the United States. The outcome will also affect the only minority group, people with disabilities, that is open to all regardless of race, gender, nationality, sexual orientation, income, place

[2] U.S. Dep't. of Commerce,Statistical Abstract of the United States 1994 at 137 (114th ed. 1994)(Table No. 202). Census data is not available for people with severe disabilities who are institutionalized.

of residency, political affiliation, or any other characteristic, and the only minority group, from a statistical viewpoint, which only 9 percent of its members join at birth.

There are five primary bases for asserting that people with severe disabilities, including nonterminal disabilities, are the actual and potential victims of a right to assisted suicide:

1. Courts in numerous jurisdictions have ruled that people with severe but nonterminal disabilities may legally be denied suicide prevention that nondisabled people routinely receive, but are to be treated like terminally ill people, with respect to the withholding and withdrawal of life sustaining medical treatment. [3]

2. The diagnosis and prognosis of terminal illness is inherently uncertain, as respondents themselves admit. [4] In addition, many doctors conclude that lives of people with severe disabilities are not worth saving, solely because of their disabilities. The potential for error and abuse against people with severe disabilities is too great.

3. Over three quarters of Jack Kevorkian's assisted suicides involved people who were clearly not terminally ill under

[3] See infra at 7-10.

[4] Timothy Quill,et al, Sounding Board: Care of the Hopelessly Ill, New Eng. J. of Med. 1380, 1381, Nov. 5,1992.

accepted medical definitions, but were only severely disabled. [5]

4. In the Netherlands, a country in which assisted suicide has been widely accepted and practiced for many years and the country often referred to as "the model" for the United States, a governmental report demonstrates that many people with nonterminal disabilities have been killed, and thousands have been killed involuntarily. [6]

5. Well-known proponents of assisted suicide have written that it should be applied to people with nonterminal disabilities. In Final Exit, Hemlock Society founder Derek Humphry writes,

> What can those of us who sympathize with a justified suicide by a handicapped person do to help? When we have statutes on the books permitting lawful physician aid-in-dying for the terminally ill, I believe that along with this reform there will come a more tolerant attitude to the other exceptional cases.

Many cases in which state courts have expanded the right to refuse treatment demonstrate that prejudice, stereotypes and devaluation of people with disabilities have already had a substantial

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[5] See Appendix A or a list of Kevorkian's "patients" by age, diagnosis and health status at the date of death.

[6] Paul J. van der Maas, et al., Euthanasia and Other Medical Decisions Concerning the End of Life, 338 Lancet 669, 672 (1991).

adverse impact on members of this minority group. Flagrant prejudice against people with disabilities pervades each decision.

Elizabeth Bouvia wanted medical support while starving herself to death. She had blamed herself for her parents' divorce. When she was ten her mother placed her in an institution, visiting her only twice in eight years. At eighteen, she moved to her own apartment, earned a college degree and began working on a master's degree. She had a series of emotional blows, including a miscarriage, the death of her brother, serious financial distress, withdrawal from graduate school because of discrimination, and separation from her new husband. [7] A nondisabled person with this history, who refused nutrition and requested physician assistance to commit suicide, would have been diagnosed as suicidal and provided suicide intervention and treatment. But because Ms. Bouvia also had cerebral palsy, a lifelong, nonterminal disability, it was concluded that her decision to die was reasonable and not deserving of intervention. [8] However, only following two years of

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[7] See L. Hearn, It's More of a Struggle to Live than Die, Chi. Trib. Feb. 8, 1984, Sec. 51-53;Robert A. Bernstein, Accept the Disabled, N.Y. Times, Jan. 10, 1984, at A23; David.Gelman & Daniel Pedersen, The Most Painful Question, Newsweek, Jan. 16, 1984, at 72; Paul K. Longmore, Elizabeth Bouvia, Assisted Suicide and Social Prejudice, 3 Issues in Law & Med. 141, 153 (1987).

[8] Much to the dismay of members of the disability community, including amici, death row prisoners receive more suicide prevention than Ms. Bouvia, Mr. Bergstedt and other persons with severe disabilities. See e.g., Autry v. McKaskle, 727 F.2d 358 (5th Cir. 1984).

lengthy court proceedings did Ms. Bouvia decide not to exercise her newly won right.

Kenneth Bergstedt had quadriplegia and used a ventilator. Throughout his 30 years of life, Mr. Bergstedt was dependent on his father, who, fearing he would soon die of lung cancer, supported his son's decision to die. A psychiatric report before a lower court declared Mr. Bergstedt to be depressed but presumed this was due to "the quality of life for this man...." [9] Mr. Bergstedt believed that he would be forced to live in a nursing home after his father's death and was unaware of in-home service alternatives. The Nevada Supreme Court pointed out that Mr. Bergstedt's

> suffering resulted more from his fear of the unknown than any source of physical pain.... It is equally clear that if Kenneth had enjoyed sound physical health, but had viewed life as unbearably miserable because of his mental state, his liberty interest would provide no basis for asserting a right to terminate his own life with or without the assistance of others. [10]

Ruling after his death, even the Nevada Supreme Court, which had supported Mr. Bergstedt's request for physician assisted suicide, recognized that he had not been properly informed and had not made

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[9] McKay v. Bergstedt, 801 P.2d 617, 637(Nev. 1990)(dissent observing that "[w]ith this kind of support it is no wonder that he decided to do himself in").

[10] Id. at 624-25 (emphasis added).

a free and intelligent life-or-death decision. If he were still alive, the court said "it would have been necessary to fully inform him of the care alternatives that would have been available to him after his father's death or incapacity." [11]

David Rivlin was paralyzed as a result of a surfing accident a full eighteen years before he committed suicide with the aid of medical support. He had no terminal illness, but he used a ventilator. He was confined to a nursing home in Michigan against his will because of the lack of adequate in-home support services at that time. In addition, his relationship with his fiance had recently ended. [12] Mr. Rivlin was given his "right to die" but was never offered the options he expressly requested to live in the community.

Larry McAfee, a thirty-four year old man with quadriplegia as a result of an accident, was transferred from one institution to another "like a sack of potatoes" over a period of four years. [13] Georgia did not pay for community support but would pay only for the

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[11] Id. at 628. Presumably, these care alternatives included the personal assistance that millions of other people with severe disabilities receive and with which they live in the community.

[12] Stanley S. Herr, et al., No Place to Go: Refusal of Life-Sustaining Treatment by Competent Persons with Physical Disabilities, 8 Issues in Law & Med.3,13-15 (1992).

[13] Peter Applebome, An Angry Man Fights to Die, Then Tests Life, N.Y.Times, Feb. 7,1990, at A 1.

cost of nursing home care [14] and for intensive care in a hospital unit where he lived for eight months, even though he was not ill, let alone critically or terminally ill. [15] The Georgia Supreme Court affirmed the lower court's assessment that Mr. McAfee was hopelessly injured. [16] In the nursing home, he was told when to eat, sleep, and even what he could watch on his own video recorder. [17] Nevertheless, after disability rights advocates including members of the amici communicated with Mr. McAfee, he changed his mind. By the time Mr. McAfee won his so-called "right to die," he had worked with disability advocates to get out of the nursing home and pursue work as an engineer using computer aided drafting. Mr. McAfee had experienced how people with severe disabilities are devalued as human beings and was quoted as saying,

> You're looked upon as a second-rate citizen. People say, 'you're using my taxes. You don't deserve to be here. You should hurry up and leave.' You reach a point where you just can't take it anymore. [18]

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[14] See also, Helen L. v. DiDario, 46 F.3d 325 (3d Cir.1995) cert. denied 116 S.Ct. 64 (1995) sub nom. Secretary of DPW of Pa. v. Idell S.

[15] Steven A.Holmes, Disabled People Say Home Care Is Needed to Use New Rights, N.Y. Times, Oct. 14, 1990, at Sec.1,2;

[16] State v. McAfee, 259 Ga. 579, 385 S.E.2d 651,652 (Ga. 1989).

[17] Joseph Shapiro ,Larry McAfee, Invisible Man:The Agonizing Fight to Prevent Legalized 'Suicide', U.S. News &World Rep., Feb.19, 1990, at 59, 60.

[18] Id at 60

These four cases are examples of discrimination against and devaluation of people with disabilities. These decisions occurred because the general public, including judges and physicians, share common societal reactions to people with severe disabilities:

1. nondisabled persons fear that they will become disabled themselves and assume that having a severe disability is worse than death itself;

2. nondisabled persons often view people with severe disabilities as lacking in "quality of life," and such people are to be pitied instead of being granted civil rights or equal legal protections; and

3. to many nondisabled persons, disability falsely implies entrapment, loss of control, and loss of dignity.

As a consequence of these reactions, persons with severe disabilities are segregated, put out of sight in institutions, or neglected, abandoned, abused, and increasingly assisted to die. These public misconceptions, however, are refuted by research studies on disabled people's quality of life. [19]

Each of these cases dismissed the state interest in protecting

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[19] See e.g., J.R.Bach & M.C.Tilton, Life Satisfaction and Well Being Measures in Ventilator Assisted Individuals with Traumatic Tetraplegia, 75 Arch. of Physical Med. & Rehab. 626 (1994).

the lives of these disabled individuals and found a "right to die" through the withdrawal of life-sustaining treatment. However, the courts specifically distinguished any right involving active physician-assisted suicide. Before this Court is the request to obliterate this distinction.

Reviewing the people whom Jack Kevorkian assisted in committing suicide also demonstrates the potential for uncontrolled discrimination against people with disabilities, if this Court sanctions active physician-assisted suicide. Of the 40 people who died between June 4,1990 and September 7, 1996 with the assistance of Kevorkian, at least 28 people had diseases that were not life-threatening and autopsies revealed they were not terminally ill. [20] For example, nine of them had multiple sclerosis. As the New York Times recently reported in connection with these people,

> multiple sclerosis is not a fatal disease.... Its tendency to wax and wane repeatedly and unpredictably can have patients wavering back and forth between elation and despair.... [T]he depression that often accompanies the disease is a treatable condition.... [S]ervices are available to help every person with illness live a more productive and comfortable life and that whatever the state of a person's disability, life need not be worthless. [21]

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[20] Thomas Maier, Waiting at Death's Door, Newsday, Sept. 8, 1996, at A 4-5. See Appendix A.

[21] Jane E. Brody, Putting Emphasis on Assisted Living with M.S., N.Y. Times, October 23, 1996 at C 11.

Like those people who had multiple sclerosis, most of Kevorkian's other "patients" did not have terminal illnesses nor did they receive appropriate services to help make life meaningful. For example, **Janet Adkins**, age 54, who died June 4, 1990, was in the early stages of Alzheimer's, was not terminally ill, and her own doctor said she had ten years of productive life ahead of her. She never met or spoke with Kevorkian until two days before her death. According to an aunt, "She did not want to be a burden to her husband and family." [22] **Marjorie Wantz**, age 58, who died October 23, 1991, had no life-threatening condition, had reportedly experienced pelvic pain, but an autopsy found she had no apparent illness or disease. [23] **Sherry Miller**, 42, who died October 23,1991, had multiple sclerosis and could have lived for many years but felt she was "becoming a burden on people," and she had suffered from depression but did not want to take the medication for it. [24] **Elaine Goldbaum** had financial problems and

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[22] Georgea Kovanis, Profession Condemns Doctor, Detroit Free Press, June 7, 1990 at 1A; Doctor Ordered Not to Use Suicide Device, San Francisco Chronicle, June 9, 1990 at A 1; Stuart Wasserman, What Drove Woman to Suicide Machine, San Francisco Chronicle, June 7, 1990 at A 2.

[23] James A. McClear, Murder Charges for Dr. Death? Detroit News, Dec. 19, 1991 at 1A.

[24] Id.

feared losing her house, [25] **Jonathan Grenz** was said to be depressed and "overwhelmed with grief" following his mother's death, [26] and **Ali Khalili** had told his doctor that "the quality of his life had been compromised by an anxiety state." [27] Kevorkian assited them all to die.

These people represent the extent of discrimination that exists in our society; with appropriate treatment and services, many of them would be alive today. It is against the backdrop of these and other cases, reflecting society's growing support of a "right to die" for people with severe disabilities, that your amici request protection from the very real threat to the lives of people with disabilities that will result from a right to assisted suicide through active measures.

B. Denying People With Disabilities The State Benefit Of Suicide Prevention And Enforcement Of Abuse, Neglect And Homicide Laws Violates The ADA.

Lethal discrimination against people with severe disabilities and functional limitations is an integral and pervasive part of America's twentieth century history. The forms of this lethal discrimination include:

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[25] Robert Ourlian & Mike Martindale, Kevorkian Assists in 12th Suicide, Detroit News, Feb. 9, 1993 at 1B,6B.

[26] Carol J. Castaneda & Robert Davis, Kevorkian: Death Must Be An Option, USA Today, Feb. 22, 1994, at 1A, 2A.

[27] Don Terry, While Out on Bail, Kevorkian Attends a Doctor's Suicide, N.Y. Times, Nov. 23, 1993 at A 1,B 9.

1. euthanasia, where nondisabled persons advocated for the involuntary euthanasia of 60,000 disabled persons in institutions and five times as many outside, since in these "hopeless" cases "we have no fear of error"; [28]

2. eugenics "favoring the killing of defective children;" [29]

3. involuntary sterilization of persons with developmental and physical disabilities; [30]

4. denial of life-saving medical assistance especially to

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[28] F.Kennedy, The Problem of Social Control of the Congenital Defective, 99 Am. J. Psych. 13-16 (1942). See also, The Right to Kill, Time, Nov. 18, 1935, at 53-54 (where a Nobel Prize winner at the Rockefeller Institute urged that "sentimental prejudice... not obstruct the quiet and painless disposition of incurable... and hopeless lunatics"); D. McKim, Heredity and Human Progress 189,193 (1900)(where a respected New York physician advocated the elimination of all severely handicapped children, including "idiots," most "imbeciles, and the greater number of epileptics, for society's protection, via a "gentle, painless death" by the inhalation of carbonic gas).

[29] D.B. Shurtlett, Myelodysplasia: Management and Treatment, 10 Current Problems in Pediatrics 1, 8 (1980). See Nat Hentoff, Are Handicapped Infants Worth Saving? Village Voice, Jan 8, 1991, at 18; Richard J. Neuhaus, The Return of Eugenics, Commentary, Apr. 1988, at 15-26.

[30] Although the Court recognized the historical practice of "'putting away ... the offspring of the inferior, or of the better when they chance to be deformed' [would]do ...violence to both the letter and spirit of the Constitution," Meyer v. Nebraska, 262 U.S. 390, 401-02 (1923), three years later it upheld the constitutionality of sterilization imposed by a State because Carrie Buck was labelled "feeble-mindedness." Buck v. Bell, Superintendent of the Virginia Colony for Epileptics and Feeble Minded, 274 U.S. 200, 207 (1927). Buck ratified the view of the feebleminded as "a menace," holding: "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind." Id.

children with severe physical disabilities; [31] and

5. withdrawal of medical treatment. [32]

This Court has acknowledged that at least one of the forms of this discrimination, the practice of withholding lifesaving medical assistance by medical professionals from children with lifelong severe disabilities, has a "history of unfair and often grotesque mistreatment" arising from a legacy of "prejudice and ignorance" and continuing well into the 20th century. City of Cleburne, Texas v. Cleburne Living Center, 105 S. Ct. 3249, 3262 (Stevens, J., joined by Burger, C.J., concurring), 3266 (Marshall, joined by Brennan & Blackmun, JJ., concurring)(1985).

Congress clearly understood this history when, in 1990, it enacted the ADA, the basic civil rights statute for people with disabilities. After extensive hearings, Congress made extensive

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[31] Studies reveal that many physicians, a majority in some specialities, oppose lifesaving surgery for babies with lifelong disabilities. A.Shaw, et al., Ethical Issues in Pediatric Surgery, 60 Pediatrics 588, 590 (1977); R.H. Gross, et al., Early Management and Decision-Making for the Treatment of Myelomeningocele, 72 Pediatrics 450, 456 (1983) (reporting on the results of selection of handicapped newborns for treatment between 1977 and 1982 at Oklahoma University Health Sciences Center that babies were provided - or denied - treatment based on such factors as their ambulatory potential, according to a "formula that also factored in the "contribution anticipated from his home and family and society"); D. Crane, The Sanctity of Social Life at 96-98 (1975) (documenting that surgeons at a teaching hospital were actually less likely to perform surgery on Down syndrome children with heart defects than survey studies would predict).

[32] See e.g., Elizabeth Bouvia, Kenneth Bergstedt, David Rivlin and Larry McAfee, supra at 7-10.

Findings:

historically, society has tended to isolate and segregate individuals with disabilities, and despite some improvements, such forms of discrimination continue to be a serious and pervasive social problem;

unlike individuals who have experienced discrimination on the basis of race, color, sex, national origin, religion, or age, individuals who have experienced discrimination on the basis of disability have often had no legal recourse to redress such discrimination;

individuals with disabilities continually encounter various forms of discrimination, including outright intentional exclusion..., segregation, and relegation to lesser ... benefits...;

census data, national polls, and other studies have documented that people with disabilities, as a group, occupy an inferior status in our society, and are severely disadvantaged...;

individuals with disabilities are a discrete and insular minority..., subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society, based on characteristics that are beyond the control of such individuals and resulting from stereotypic assumptions not truly indicative of the individual ability of such individuals to participate in, and contribute to society; and

the continuing existence of unfair and unnecessary discrimination and prejudice denies people with disabilities the opportunity ... to pursue those opportunities for which our free society is justifiably famous.

42 U.S.C. §§12101(a)(2),(4)-(7)and (9)(emphases added).

To address and remedy this pervasive and relentless discrimination, Congress substantively required that "no qualified individual with a disability shall, by reason of such disability, be

excluded from participation in or be denied the benefits of the services, programs, or activities of any public entity...." 42 U.S.C. § 12132. The same prohibition applies to hospitals and physicians. 42 U.S.C. § 12182(b)(2)(A)(iii). Elizabeth Bouvia, Kenneth Bergstedt, Janet Adkins, Marjorie Wantz, Sherry Miller and the other people discussed above had disabilities (or were perceived to have disabilities) and all of them, "by reasons of [their] disability," were denied the state's benefits of suicide prevention and/or enforcement of abuse, neglect, and homicide statutes. The states concluded that their fundamental interests in saving lives applied only to people without severe disabilities.

Pursuant to the ADA's explicit statutory mandate, 42 U.S.C. § 12134, the U.S. Department of Justice promulgated federal regulations elaborating on the statutory definition of discrimination. Specifically, the regulations provide that a state, as well as hospitals and doctors, discriminate when they either deny or do not afford an opportunity for people with disabilities to benefit from services either equal to or as effective as that afforded nondisabled persons. See e.g., 28 C.F.R. § 35.130(b).

Providing assisted suicide only for people with severe disabilities and conversely denying suicide prevention services only for people with severe disabilities violates the ADA in at least four

respects:

1. The presence or absence of a severe disability determines whether state and local governments enforce laws requiring health professionals to protect individuals who pose a danger to themselves. The disability, instead of the risk of suicide, determines the enforcement.

2. The presence or absence of a severe disability determines whether the state and medical practitioners respond to expressions of suicidal intent in people with disabilities with the application of lethal measures that are never applied to people without disabilities. The existence of a severe disability will be the reason for the denial of treatment that nondisabled persons routinely receive. Society's growing support of such discrimination is founded on inaccurate assumptions about the needs of persons with incurable health conditions, the role and authority of physicians, and the nature and significance of requests to die as they are understood and valued by physicians. [33]

3. The presence or absence of a severe disability determines whether state and local governments investigate or enforce potential medical malpractice, such as failure to provide pain medication, failure

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[33] The clinical aspects of such discrimination are explained in Appendix B, excerpts of Affidavit of Carol Gill, Ph.D. from the record in Lee v. Oregon, 869 F. Supp. 1491 (Ore.D., 1994)

to establish an accurate diagnosis, prognosis and treatment plan, and failure to ensure informed consent. If one has a severe disability, each of these are treated differently than if one were nondisabled, resulting in a double standard that depends only on the existence of a severe disability.

4. The presence or absence of severe disability determines whether and the extent to which state and local governments investigate and enforce abuse and neglect and homicide statutes in cases reported as assisted suicides. Amici's experiences demonstrate that noninvestigation and nonenforcement are common practices when it comes to the death of people with disabilities. [34]

The existence of a disability should never be the basis for these distinctions.

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[34] There are already documented cases of discriminatory enforcement of homicide statutes. **Myrna Lebov**, a woman with nonterminal multiple sclerosis, was pressured and assisted to die by her husband, Mr. Delury who stated that he had repeatedly told his wife that she was a terrible burden on him, telling her that she was "a vampire sucking [his] life away." Herbert Hendin, Dying of Resentment, N.Y. Times, March 21, 1996 (Op-Ed Page). Mr. Delury plead guilty to a charge of attempted manslaughter and was sentenced to only 6 months in prison.

A mother recently killed her brain injured non-verbal teenage daughter. The judge said her actions were understandable, andt other parents could be expected to react in the same way. She was sentenced to community service. B. Harris,Mom Freed in Mercy Killing, Spokesman-Review, Jan. 10, 1996 at A1, A7.

II. Adequate Safeguards Cannot Be Adopted To Protect People With Disabilities From Assisted Suicide Abuse And Therefore An Unequivocal Rule Must Be Established Prohibiting Assisted Suicide.

A. Any Purported Limitation Of The Right To Assisted Suicide To Terminally Ill Persons Will Not Protect People With Severe Disabilities.

Given the "history of purposeful unequal treatment" to which people with disabilities are subjected and the "continuing existence of unfair ... discrimination and prejudice," 42 U.S.C. § 12101 (a)(7) & (9), adequate assisted-suicide safeguards cannot and will not prevent abuse against people with disabilities. History, contemporary attitudes and biases, the Netherlands, as well as prior judicial decisions, demonstrate that safeguards against abuse in assisted suicide cannot be developed. Amici discussed the current practices which demonstrate that assisted suicide has not and will not be limited to terminally ill persons. [35] As long as society, including the medical profession, demonstrates ignorance and prejudice regarding the lives of people with disabilities, no safeguards can be trusted to contain the torrent of discrimination that will be unleashed by lifting the ban on assisted suicide.

At issue in the present case is nondisabled peoples' intense fear of becoming disabled. When a person with a disability states a

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[35] See infra at 7 -10.

desire to die, nondisabled people believe the request is natural and reasonable because they believe that living with a severe disability is a life of dependency, indignity and helplessness; in short, worse than death. The wish to die agrees with the nondisabled view that the primary problem for disabled people is the permanent disability and/or dependence on life aids. Medical professionals, jurists and the public consistently ignore underlying treatable depression, lack of health care or other supports, and exhaustion from confronting systemic discrimination. When medical professionals and the media use phrases like "imprisoned by her body," "helpless," "suffering needlessly," and "quality versus quantity of life," purportedly in a humanistic and compassionate way, they are really expressing very primitive human fears of severe disability and a very misguided condemnation, "I could never live like that." Society translates these primitive emotions into a supposedly rational social policy of assisted suicide. Whenever

> permanent disability is [defined] as the problem, death is the solution.... [T]he wish to die is transformed into a desire for freedom, not suicide. If it is suicide at all, it is 'rational' and, thereby, different from suicides resulting from [the same] emotional disturbance or illogical despair [that nondisabled persons face]. [36]

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[36] C.J.Gill, Suicide Intervention for People With Disabilities: A Lesson in Inequality, 8 Issues in Law & Med.37, 39 (1992).

The medical profession is not immune to these erroneous assumptions. Research shows that doctors frequently project the "quality of life of chronically ill persons to be poorer than patients themselves hold it to be, and give this conclusion great weight in inferring, incorrectly, that such persons would choose to forgo life-prolonging treatment." [37] It is particularly important to note that research on suicidal feelings among people with terminal illnesses demonstrates that such feelings are remediable through other means, including pain management, hospice services and counselling. [38] As long as physicians believe that a person with a severe disability has a "life unworthy of living," [39] lethal errors and abuses will occur.

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[37] S. Miles, Physicians and Their Patients' Suicides, 271 J.A.M.A. 1786 (1994).

[38] Most death requests, even in terminally ill people are propelled by despair and treatable depression. Herbert Hendin and Gerald Klerman, Physician-Assisted Suicide: The Dangers of Legalization, 150 Am. J. of Psych. 143 (Jan.1993).

[39] It was in Germany in the 1930s, preceding the well-known holocaust of Jewish people , that the Nazis instituted a program to eliminate approximately 200,000 persons with physical and mental disabilities because their lives were "unworthy of living." See e.g., H. Gallagher, By Trust Betrayed (1990); R. Proctor, Racial Hygiene - Medicine Under the Nazis (1988); R. Lifton, The Nazi Doctors - Medical Killing and the Psychology of Genocide (1986) (the medical profession was not coerced but were willing initiators); G.Aly, The Legalization of Mercy Killings in Medical and Nursing Institutions in Nazi Germany from 1938 Until 1941, Int. J. of Law And Psychiatry 145 (1984). The same attitude recently pervaded China's policies in the killing of children with disabilities. Human Rights Watch/Asia, Death by Default - A Policy of Fatal Neglect in China's State Orphanages (1996).

B. Any Purported Limitation Of A Right To Assisted Suicide Only In Cases Of "Voluntary" Requests Will Not Protect People With Disabilities From Abuse.

As long as people with disabilities are treated as unwelcome and costly burdens on society, assisted suicide is not voluntary but is a forced "choice." Amici are profoundly disturbed by the finding of a constitutional right for assisted suicide in a society which refuses to find a right to adequate and appropriate health care to stay alive. Until society is committed to providing life supports, including in-home personal assistance services, health care, and technological supports, then there is not voluntary choice.

Our nation's health care system has not responded adequately or consistently to the health needs of people with disabilities. Now managed health care, with its emphasis on cost containment and the inevitable denial of health care, will further abridge the choices and endanger the lives of people with disabilities.

Without access to competent medical care, options and information about disability, people with severe disabilities are not able to make informed decisions. Without the professional commitment to help make living worthwhile for people with disabilities, which is the core of suicide prevention, people with disabilities will not receive the support necessary for informed and voluntary decisions.

Additionally, there is substantial evidence that physicians and other health care providers will engage in euthanasia in the absence of a patient's clear request to die, and even in opposition to a clear request to live:

1. Recent medical studies indicate that involuntary "do not resuscitate" ("DNR") orders are not uncommon. [40] Many members of your amici have been repeatedly requested and pressured to sign DNR requests. Maria Matzik, a Not Dead Yet and ADAPT member and a 34 year old ventilator user, was told by health care professionals in a hospital that a DNR order would apply to her because she uses a ventilator, despite her express demand to the contrary.

2. Cases have been brought by health care professionals seeking authority to withhold treatment in opposition to express patient and family directives to the contrary. [41]

3. Evidence from the Netherlands demonstrates quite unequivocally that involuntary euthanasia has become widespread and frequent, even with established written safeguards in place. Specifically, according to a 1990 governmental report, 5,941 persons

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[40] D. Wassel & R. Truog, The Cardiopulmonary Resuscitation Order - - Not - Indicated Order: Futility Revisited, 122 Ann. of Int. Med. 304 (1995).

[41] E. Walsh, Spouse Says He'd Never Agree to Cut Life Support, Wash. Post, May 30, 1991, Sec. A at 3.

were given lethal injections without their consent. Of those, 1,474 were fully competent, according to their physicians. In 8% of the cases, doctors admitted there were unexplored options. Regardless of options, they euthanized unconsenting patients because of such express reasons as "low quality of life," "no prospect of improvement," "and "the family could not take any more." [42] There is no reason to believe that safeguards will work any better in the United States. To the contrary, once assisting disabled people to their deaths becomes routine in medical training and practice, no safeguards are possible behind the closed doctors' doors to protect people with disabilities against well-intentioned, but lethal prejudice exhibited by many physicians.

4. If a right to assisted suicide is created, then, as existing court precedent and state statutes involving refusal of treatment indicate, such a "right" will soon be extended in practice to incompetent persons through the use of advanced directives and surrogate decision-makers. Research shows that families are likely to believe that assisted suicide is a desirable option, and that a disabled family member would want assisted suicide, even though that family member in fact does not

[42] Richard Fenigsen , Euthanasia: The Medicine and Fear, Doctor Assisted Suicide and the Euthanasia Movement,G. McCuen, ed. at 76, 80 (1994); see also Maas, supra at n. 6.

want aid in dying.[43] Amici contend that a right to assisted suicide for competent adults will increase the danger of lethal decisions by families, whether well-intentional or otherwise.

5. The history of discrimination against persons with disabilities in health care settings, coupled with current developments in managed care, demonstrates that assisted suicide is the easiest and most financially profitable way to address the needs of persons with disabilities. With assisted suicide, a doctor under a capitated health care system will not have to exceed his utilization rate on a severely disabled patient. There are no safeguards that can protect against these prejudices and realities.

Finally, no system of safeguards can control conduct which results in the death of the primary witness to any wrongdoing or duress. The only "safeguard" that offers some protection against abuse is that assisted suicide remain illegal and socially condemned for all citizens equally. As assisted suicide becomes more and more acceptable, the threat of criminal prosecution is the only remaining protection to which people with severe disabilities, including terminal illnesses, can turn. For example, 16% of nurses report engaging in the practices,

[43] H.G.Koenig, et al., Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide, 156 Arch. of Int. Med., 2240 (1996).

sometimes without the consent of the patient. [44] In the absence of any potential for criminal liability, no meaningful barrier to active involuntary euthanasia will exist to protect the lives of members of this minority group.

III. If This Court Finds That Either A Constitutional Or Statutory Right To Assisted Suicide Exists, Then This Right Should Be Afforded To Everyone Without Discriminating Against People Because Of Health Or Disability Status.

The proposed right to assisted suicide discriminates, singling out people with severe disabilities as fit to die. Since this discrimination is so pervasive in our society, amici urge that if any right to obtain assistance to control one's death exists, it should apply to everyone in a nondiscriminatory manner and not be limited to persons with severe disabilities, including terminal illnesses.

If the Constitution requires that the state's interest in the preservation of life (through suicide prevention and other laws) is vitiated for some people because of their health status, then why should the state interest not also be discounted for other persons? Why should one's autonomy or right to control one's death be limited to persons with severe disabilities? Why exclude from this right persons enduring extreme, unabating psychological suffering due to the irreversable loss

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[44] D. A. Asch, The Role of Critical Care Nurses in Euthanasia and Assisted Suicide, 334 N. Eng. J. of Med.,1374 (1996).

of loved ones? There is no constitutional basis for drawing a bright line on a continuum between disabled and nondisabled. Such a distinction would stand on shifting sands of arbitrary classifications and assessments, as well as changing medical and technological expertise and developments.

Moreover, if proponents of assisted suicide believe that adequate safeguards against treatable suicidal feelings can be established, then they should be willing to allow physician assistance for every citizen, regardless of their health status, after those safeguards have been observed.

Amici ask the Court to be believe them when they state that disability-based discrimination in this culture is deep-seated, virtually unconscious, pervasive and overwhelming. This discrimination against millions of Americans must be understood and reversed, in ways that few can even envision, long before we discuss expanding the ways in which society's unwanted can be killed. But if physician-assisted suicide will become a right for some, then it should be for all. The same safeguards, or lack of safeguards, that apply to some must apply to all, without discrimination.

CONCLUSION

The circuit courts' conclusions that people with disabilities are not threatened by physician-assisted suicide is false, based on virtually every court decision to date, as well as on the actual practice in our society. The fact that proponents of assisted suicide continue to dismiss and marginalize the input of the disability rights community on this topic leads amici to believe that they may actually feel that their untimely deaths are ultimately acceptable in the interest of the "greater good," or even only in the interest of their individual need to maintain control in an uncertain and often cruel world.

People with disabilities request this Court protects their lives, to stand as perhaps the last barrier to the "right to die" juggernaut of the recent decade, to recognize that cloaked in the false rhetoric of "personal autonomy," physician assisted suicide threatens the remaining rights of a profoundly oppressed and marginalized people.

Respectfully submitted,

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Nobember 12, 1996

APPENDIX A

The following people were Kevorkin's "patients" through September 7, 1966: [1]

NAME, AGE, DATE DIED, STATUS AND CONDITION AT TIME OF DEATH

JANET AKINS, 54, 6/4/90. Not Terminal. Had Alzheimer's disease.
SHERRY MILLER, 43, 10/23/91. Not Terminal. Had multiple sclerosis with disorganization of motor control in legs and arms.
MARJORIE WANTZ, 58, 10/23/91.Not terminal. Had severe pelvic pain.
SUSAN WILLIAMS, 52, 5/15/92.Not terminal. Had multiple sclerosis and was blind.
LOIS HAWES, 52, 9/26/92. Terminal stages of lung cancer.
CATHERINE ANDREYEV, 46, 11/23/92. Terminal stages of breast cancer.
MARCELLA LAWRENCE, 67, 12/15/92. Not terminal. Had heart disease, emphysema and arthritis.
MARGUERITE TATE, 70, 12/15/92.Terminal stages of Lou Gehrig's disease.
JACK MILLER,53, 1/20/93. Terminal stages of bone cancer. Also had emphysema.
STANLEY BALL, 82, 2/4/93. Not terminal. Had pancreatic cancer.
MARY BIERNAT, 73, 2/4/93. Had breast and chest cancer. Unclear whether terminal.
ELAINE GOLDBAUM,47, 2/8/93. Not terminal. Had multiple sclerosis, was blind and use a wheelchair.
HUGH GALE, 70, 2/15/93. Unclear whether terminal. Had emphysema and congestive heart disease.
JONATHAN GRENZ, 44, 2/18/93. Terminal. Had throat cancer.

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[1] Thomas A. Maier, Waiting at Death's Door, Newsday, September 8, 1996 at A40, A51, & A53.

MARTHA RUWART, 41, 2/18/93. Terminal. Had duodenal and ovarian cancer.
RON MANSUR, 54, 5/16/93. Unclear whether terminal. Had lung and bone cancer.
THOMAS HYDE, 30, 8/4/93. Terminal. Had Lou Gehrig's disease.
DONALD O'KEEFE,73, 9/9/93. Terminal. Had bone cancer.
MERIAN FREDERICK, 72, 10/22/93. Not terminal stage of Lou Gehrig's disease.
ALI KHALILI, 61, 11/22/93.Not terminal. Had progressive bone disease and multiple myeloma.
MARGARET GARRISH, 72, 11/26/94. Not terminal. Had double amputation from chronic degenerative joint disease.
JOHN EVANS, 77, 5/895. Not terminal. Had chronic lung disease.
NICHOLAS LOVING, 27, 5/12/95. Not terminal stage of Lou Gehrig's disease.
ERIKA GARCELLANO, 60, 626/95. Not terminal stage of Lou Gehrig's disease.
ESTHER COHAN, 46 8/25/95. Not terminal. Had multiple sclerosis.
PATRICIA CASHMAN, 58, 11/8/95. Not terminal. Had breast cancer.
LINDA HENSLEE, 48, 1/29/96. Not terminal. Had multiple sclerosis.
AUSTIN BASTABLE, 53, 5/6/96. Not terminal. Had multiple sclerosis.
RUTH NEUMAN, 69, 6/10/96. Not terminal. Was overweight and had diabetes.
LONA JONES, 58, 6/18/96. Not terminal. Had a brain tumor.
BETTE LOU HAMILTON, 67, 6/20/96. Not terminal. Had a degenerative neurological disease.
SHIRLEY CLINE, 63, 7/4/96. Not terminal. Had colon cancer.
REBECCA BADGER,39, 7/9/96. Not terminal. Had multiple sclerosis.
ELIZABETH MERCZ, 59, 8/6/96.Not terminal. Had Lou Gehrig's disease.
JUDITH CURREN, 42 8/15/96. Not terminal. Had chronic

fatigue syndrome and muscle disorder.
DORTHA SIEBENS, 76, 8/20/96. Not terminal. Had Lou Gehrig's disease.
PATRICIA SMITH, 40, 8/22/96.Not terminal. Had multiple sclerosis.
PAT DIGANGL, 66, 8/22/96. Not Terminal. Had debilitating muscle illness.
JACK LEATHERMAN, 73, 9/2/96. Terminal. Had pancreatic cancer.
ISABEL CORREA, 60, 9/7/96.Not terminal. Had severe pain from a spinal cord condition.

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APPENDIX B

Excerpts from Affidavit of Carol Gill, Ph.D. in record in Lee v. Oregon, 869 F. Supp. 1491 (Ore. D. 1994).

I am a clinical psychologist specializing in issues affecting persons with disabilities, pain, and/or chronic illnesses. . . My former positions include: Director of Rehabilitation Psychology at Glendale Adventist Center; Commissioner in Psychology on the Los Angeles County Commission on Disability ; and Acting Director of the Program in Disability and Society at the University of Southern California . . . In addition . . . I have been physically disabled since contracting polio in childhood and relying on a power wheelchair for mobility and a ventilator for respiration during the night . . .

I have observed that a primary source of depression and despair in clients with disabilities and chronic progressive illnesses is their demoralization by social discrimination in daily life. After struggling with employment bias, unaccommodating and selective health services, lack of accessible and affordable housing, and lack of accessible transportation, many of my clients and research subjects have expressed feelings of severe emotional exhaustion commonly referred to as "burn-out." In fact, the most frequently repeated theme from persons with disabilities and illnesses that I have encountered in the last decade has been, "I can live with my physical condition but I'm tired of struggling against the way I'm treated."

In the case of spinal cord injury, for example . . . [it] is quite common for persons who first learn of their paralysis and are confronted with assistive technology and unfamiliar procedures to express the desire to die; and to express it forcefully and consistently for weeks. Months later, however, most of those patients thank their doctors and families for supporting their lives instead of concluding with their earlier despair . . . .

[W]hen the "critical life stress" involves a life-threatening illness or disability, the process of adjustment often takes considerably longer. Therapists experienced in working with terminally ill and irreversibly disabled individuals report a series of stages - including shock, grief, despair, and resolution - that are navigated before such individuals regain basic emotional control . . . However, emotional disorder can well be hidden and remain undetected unless carefully assessed by properly trained professionals. Most physicians are not trained to identify hidden depression, treatable suicidal intent, and other non-flagrant psychiatric disorders. Studies have revealed that a significant portion of persons who attempt suicide seek medical attention shortly before the event and that their physicians typically remain unaware of their emotional distress and need for psychological intervention . . . Attending physicians, therefore, have not proven to be qualified gatekeepers in determining a patient's need for psychological services.

In my clinical practice and in my subsequent education and research contacts, I have heard repeated complaints from persons with incurable health conditions that their physicians are often unaware of their needs, devaluing their lifestyles, and uninformed about such important options as personal in-home assistance, independent living centers, and assistive technology. These complaints are confirmed by research . . . For example, research ... reveals that health professionals often prejudge the lives of ventilator-users as poor in quality. These negative judgments are not only at odds with the generally high life satisfaction ratings of ventilator-users themselves, but are also associated with a lack of knowledge about options for assisted ventilation and a tendency to withhold such options from patients . . . Those of us who have worked extensively with suicidal persons realize

that the wish to die can sound unwavering and can persist for many weeks and yet be characterized by deep ambivalence. The presence of a terminal illness or even substantial physical suffering does not in any way diminish the possibility of significant conflict between the wish to die and the desire to live.

It is extremely dangerous to respond to the expression of a death wish by providing the means to die. That type of response, especially if it comes from a respected authority or representative of society (e.g., a physician), can unduly influence a vulnerable individual to embrace death as the "right" solution . . .

For example, the desire to die may result from the previously mentioned exhaustion after a struggle to live in the face of thwarting social barriers and discrimination. Self-destructive impulses may also represent an internalization of the stigma and devaluation society inflicts on persons with incurable conditions - an internalization of the pervasive message that physical weakness is "undignified" but that dying is "humane and dignified." Suicide may be a desperate attempt to control one's life when the surrounding environment is dismissive of one's needs or unwilling to support alternative ways to enhance self-determination, e.g., assistive technology and dignified personal assistance in one's own home. Embracing death may be a tragic effort to escape the imprisonment of a nursing home or other intolerable institutional setting. It may be an attempt to ward off impending abandonment or rejection from others who cannot cope with a loved one's physical decline. It may be a self-sacrificing measure to spare family members from the financial strain that often accompanies lingering illness in our society. The expression of a desire to die may be a poignant way of testing the waters to see if others feel it is time for the ill individual to get out of the way. These are all socially mediated reasons for wanting to die. They should be addressed through modifying the social environment, not accepting the individual's self-elimination.

The expressed desire to escape illness by dying can also be a sign of treatable clinical depression, anxiety disorder, or other mental illness. Researchers who studied terminally ill people seeking a

hastened death found that most, in fact, had a psychiatric disorder . . . Preoccupation with physical discomfort and the tendency to express emotional distress in somatic complaints is a common symptom of clinical depression. We cannot assume that simply because a person is physically ill, he or she is immune from the treatable psychiatric problems that visit many physically healthy persons have. . . . Not all persons with incurable conditions enjoy the middle-class ideal of the stable doctor-patient relationship. Many are impoverished and see a series of doctors who are assigned to them. They may opt for death because they cannot afford many of the comforts and options available to others. If they qualify for a lethal prescription, it is likely to come from a stranger who knows little about them instead of the trusted family physician envisioned by many of the more privileged . . .

In light of the disturbing facts presented above, I submit that the Oregon death with Dignity Act singles out a class of persons that society has already too quick to discard and further reduces support for and protections of their lives . . . That bias is an insidious form of prejudice that disability rights activists call "ableism" or "physicalism." A society that weighs the value of a citizen's life according to health or physical attributes is entering risky territory. When physicians are instructed to adopt such a scale with impunity, the silent and far-reaching effects on health care and on society as a whole will be as impossible to predict as to control. One of the most certain and tragic outcomes, however, is that it will lead to the wrongful premature deaths of persons who, if given basic support and reasonable options instead of a socially and medically sanctioned exit, would prefer to live.

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No. 95-1858

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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29 pp

TABLE OF CONTENTS

PAGE

TABLE OF AUTHORITIES iii

INTEREST OF THE AMICI CURIAE 2

SUMMARY OF ARGUMENT 3

ARGUMENT 4

I. THE COURT BELOW ERRED IN HOLDING THAT NEW YORK'S STATUTES CRIMINALIZING ASSISTED SUICIDE FURTHERED NO LEGITIMATE STATE INTEREST 4

A. New York Has an Interest in Regulating the Physician-Patient Relationship 6

B. New York Has an Interest in Protecting the Integrity of the Medical Profession 8

C. The Court of Appeals Usurped the Role of the New York Legislature 9

II. THE DECISION OF THE COURT OF APPEALS PROCEEDS UPON A FUNDAMENTALLY ERRONEOUS ASSUMPTION AS TO THE RELATIONSHIP BETWEEN PAINFUL TERMINAL ILLNESS AND THE PATIENT'S DESIRE FOR PHYSICIAN-ASSISTED SUICIDE 11

III. THE CONSTITUTION IS NOT THE SOURCE OF OUR FUNDAMENTAL HUMAN RIGHTS 14

CONCLUSION 23

TABLE OF AUTHORITIES

Cases PAGE

Application of President & Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.), *cert. denied*, 377 U.S. 978 (1964) 9

Bowers v. *Hardwick*, 478 U.S. 186 (1985)..... 4

Bradwell v. *Illinois*, 83 U.S. (16 Wall.) 130 (1873) ... 20

Brown v. *Board of Education*, 347 U.S. 483 (1954) ... 20

Butchers' Union Slaughter-House & Live-stock Landing Co. v. *Crescent City Live-Stock Landing & Slaughter-House Co.*, 111 U.S. 746 (1884) 17-18

City of Dallas v. *Stanglin*, 490 U.S. 19 (1989) 10n

Compassion in Dying v. *State of Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc) 9n

Cruzan v. *Director, Missouri Department of Health*, 497 U.S. 261 (1990) 9n

Damino v. *O'Neill*, 702 F. Supp. 949 (E.D.N.Y. 1987)..... 6

Donaldson v. *Lungren*, 2 Cal. App. 4th 1614, 4 Cal. Rptr. 2d 59 (Cal. App. 2d Dist. 1992) 7

Eichner v. *Dillon*, 73 A.D.2d 431, 426 N.Y.S.2d 517 (2d Dep't 1980), *aff'd as modified sub nom., Matter of Storar*, 52 N.Y. 2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, *Storar* v. *Storar*, 454 U.S. 858 (1981) 8-9, 10

Grace Plaza of Great Neck, Inc. v. *Elbaum*, 82 N.Y.2d 10, 623 N.E. 2d 513, 603 N.Y.S.2d 386 (1993) 10

PAGE

Heller v. *Doe*, 509 U.S. 312 (1993)..... 10n

Korematsu v. *United States*, 323 U.S. 214 (1944) 21

Kovacs v. *Cooper*, 336 U.S. 77 (1949)..... 10n

In re Estate of Longeway, 133 Ill. 2d 33, 139 Ill. Dec. 780, 549 N.E. 2d 292 (1989) 5

Massachusetts Board of Retirement v. *Murgia*, 427 U.S. 307 (1976) 19

Matter of Westchester County Medical Center on behalf of O'Connor, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988) 11

McNaughton v. *Johnson*, 242 U.S. 344 (1917) 10n

Minor v. *Happersett*, 88 U.S. (21 Wall.) 162 (1875) .. 20

Murphy v. *California*, 225 U.S. 623 (1912) 10n

People v. *Scott*, 79 N.Y.2d 474, 593 N.E.2d 1328, 583 N.Y.S.2d 920 (1992) 10n

Plessy v. *Ferguson*, 163 U.S. 537 (1896) 19-20

Powell v. *Pennsylvania*, 127 U.S. 678 (1888) 17-18

Sandin v. *Conner*, ___ U.S. ___, 115 S. Ct. 2293 (1995) 19

Scott v. *Sandford*, 60 U.S. (19 How.) 393 (1856) 16-17, 18, 19

Superintendent of Belchertown State School v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) 5

Thor v. *Superior Court*, 5 Cal. 4th 725, 21 Cal. Rptr 2d 357, 855 P.2d 375 (1993) 5

PAGE

United States v. *Anthony*, 24 F. Cas. 829 (C.C. N.D.N.Y. 1873) 20-21

United States v. *George*, 239 F. Supp. 752 (D. Conn. 1965) 8

United States v. *Lopez*, ___ U.S. ___, 115 S. Ct. 1624 (1995) 10n

Welch v. *Swasey*, 214 U.S. 91 (1909) 10n

Williamson v. *Lee Optical Co.*, 348 U.S. 483 (1955) .. 6

Other Authorities

U.S. Const. preamble 17

U.S. Const. art. III, § 1 ..... 16n

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John Locke, *Two Treatises on Government*, Second Treatise 14-16

BERNARD BAILYN, THE IDEOLOGICAL ORIGINS OF THE AMERICAN REVOLUTION (1967) 14n

PAGE

Robert M. Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 Fordham L. Rev. 1, 29-33 (1975) 9

Forrest Macdonald, Preface, *Novus Ordo Seclorum* (1985) 14n

Michael Stokes Paulsen, *Captain James T. Kirk and the Enterprise of Constitutional Interpretation: Some Modest Proposals from the Twenty-third Century*, 59 Albany L. Rev. 671 (1995) 17

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF *AMICI CURIAE* IN SUPPORT OF PETITIONERS

This brief *amici curiae* is respectfully submitted on behalf of Jerome J. De Cosse, Joseph George, Kenneth Prager, Richard Gallagher,[1] Robert J. Walsh, Alan B. Astrow, Ira Wagner, Mary Elizabeth Lell, Tony Barba, Lorna Cvetkovich, Kim Hardy, James Scheidler, Lynne Kavulich, Linda Long,

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[1] *Amici* De Cosse, George, Prager and Gallagher submitted affidavits describing their support for New York's prohibition against physician assisted suicide in the district court proceeding.

Steve Najarian, Richard Taylor, Ruth Taylor, Sally White and the Metropolitan Catholic Physicians Guild[2] by the Legal Center for Defense of Life, Inc. in support of Petitioners' brief to reverse the judgment of the United States Court of Appeals for the Second Circuit entered on April 2, 1996.

Pursuant to Rule 37.3 of the Rules of this Court, *Amici* have obtained and file herewith the written consent of each of the parties to the filing of this brief.

INTEREST OF THE AMICI CURIAE

Amici are physicians opposed to the practice of physician-assisted suicide. The decision of the Court of Appeals for the Second Circuit will greatly impact medical professionals, like the *amici*, who are personally and professionally opposed to physician-assisted suicide. There is bitter irony in the fact that members of the same profession that is entrusted by the

[2] The individual members of the Metropolitan Catholic Physicians Guild include Karl P. Adler, Joseph M. Andronaco, John Baker, John D. Cahill, Robert E. Campion, Elvira M. Carota, James P. Casey, Antonio Cavalli, Arnold J. Cerasoli, John A. Cinelli, Joseph B. Cleary, John W. Conroy, Albert De Martino, Joseph D. DeCarlo, Louis R. Del Guercio, Anthony Diagonale, James Doyle, William J. Farrell, Joseph C. Fink, Thomas J. Forlenza, Andrew T. Furey, Robert Furlong, James T. Geddis, Edwin A. Hagerty, Jane Haher, Ralph Imperato, Rita C. Jaeger, James L. Januzzi, Paul L. Juan, Raymond Kiernan, John P. Landi, Michael N. Lavacca, John R. Locascio, Ralph Lucariello, Robert E. Madden, Emil Maffucci, Carolyn A. Martin, Robert E. Martin, Bento R. Mascarehas, Joseph Masdeu, Martin F. McGowan, Edward J. McDermott, Charles K. McSherry, John R. Meharg, Frank A. Migliorelli, Diana I. Monti, Saverio G. Mortati, Joseph Mucci, Alfred W. Murphy, Michael Murphy, Khaschayor Nainzadeh, Nahid Nainzadeh, Thomas F. Nealon, Oscar A. Palatucci, William F. Panke, Joseph T. Pedulla, Peter Pelligrino, Charles Pierre, Louis Piro, Francis J. Porreca, Edward J. Powers, R.F. Procario, Thomas M. Reilly, Benedict M. Reynolds, Anthony Riario, Charles A. Ricciardelli, Dorothy J. Richardson, Charles A. Rizzo, Thomas D. Rizzo, J. Anthony SanFilippo, Ludovit Sevcik, Vincent Squilla, Tullio F. Tartaglia, Carlos T. Tejada, Leslie H. Tisdall, Liliana Trivelli-Alessi, and Paul Tucci.

people of New York State to preserve and protect human life are now blessed by the decision of the court below with the permission to destroy life. Accordingly, to ensure that the ethics of medical practice remain life-oriented, the Center respectfully submits this brief on behalf of *amici curiae* in support of Petitioners' argument to reverse the decision of the court of appeals.

SUMMARY OF ARGUMENT

The decision of the court of appeals is fundamentally flawed and must therefore be reversed. The court of appeals based its decision on the untenable assumption that the withdrawal of extraordinary means of life support is no different than the provision of the means to hasten death. In equating the two without any evidentiary support, the court of appeals disregarded the overwhelming medical, ethical and historical opinion to the contrary.

Even assuming *arguendo* that the court of appeals' assumption is correct and that New York State does not treat those similarly circumstanced people alike, it committed an even more unfathomable error when it held that New York State has no rational basis related to a legitimate state interest for prohibiting assisted suicide while simultaneously allowing "similarly situated" patients to discontinue life-saving treatment. To the contrary, the State has numerous compelling interests which are properly fostered by the penal sanctions against assisted suicide. The State's interests are critical: to preserve human life; to avoid a threat to the lives of those citizens least able to protect themselves against pressure to consent to an early death; to regulate the physician-patient relationship by maintaining the high ethical standards of the medical community; and to protect the members of the medical profession from the compelled violation of their professional standards and individual consciences that require them to prolong and protect human life.

Finally, and most fundamentally, in striking down New York's laws against assisted suicide, the court of appeals usurped the exercise by New York State of its classic police powers to safeguard the lives and welfare of their citizens. There is no conceivable justification either constitutional or otherwise for the decision of the court of appeals to impose its uninformed lay judgment on an issue which the New York Legislature and Executive are competent to and have addressed as recently as 1994.

ARGUMENT

I.

THE COURT BELOW ERRED IN HOLDING THAT NEW YORK'S STATUTE CRIMINALIZING ASSISTED SUICIDE FURTHERED NO LEGITIMATE STATE INTEREST

The Second Circuit held[3]—we submit correctly—that no fundamental right is infringed by New York's criminal prohibition of assisted suicide:

> "[T]he statutes plaintiffs seek to declare unconstitutional here cannot be said to infringe upon any fundamental

[3] Respondents urged the court below to recognize that they have an unfettered constitutional right to commit suicide and to receive (and, in the case of physician-respondents, to render) assistance in the furtherance thereof. Such a right, they urged, was premised on the fundamental rights to privacy and other personal decisions which themselves are tenuous at best and from which Respondents expected the court below to further infer fundamental rights to commit suicide and to receive the assistance of a third party who in turn had a fundamental right to so assist. The court below properly rejected this absurd invitation to recognize a putative right premised on a quadruple implication. *See Bowers* v. *Hardwick*, 478 U.S. 186, 193 (1985) (refusing to take an expansive view of Court's authority to "discover" new fundamental rights imbedded in the Due Process Clause).

> right or liberty. As in *Bowers*, the right contended for here cannot be considered so implicit in our understanding of ordered liberty that neither justice nor liberty would exist if it were sacrificed. Nor can it be said that the right to assisted suicide claimed by plaintiffs is deeply rooted in the nation's traditions and history. Indeed, the very opposite is true." 80 F.3d 716, 724 (2d Cir. 1996).

Having thus properly understood and applied this Court's admonition in *Bowers* v. *Hardwick*, *supra*, 478 U.S. at 194, against "judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution," the court of appeals proceeded to violate that directive under the color of applying the Equal Protection Clause.

The court of appeals erroneously held that New York State "does not treat similarly circumstanced people alike" and that New York has no rational basis for distinguishing between allowing physicians to withdraw life support upon the request of a competent patient and prohibiting physicians from complying with a patient's request for lethal drugs. In equating the withdrawal of extraordinary means of life support with the provision of a vehicle for suicide, the court of appeals unabashedly ignored the overwhelming body of medical and legal opinion to the contrary and its holding is therefore fundamentally flawed.

There is an undeniable distinction between directly causing death by an affirmative act and simply allowing death to occur by withholding treatment. The act of suicide requires the specific intent to die; the refusal of medical treatment evidences only an intent to forego extraordinary measures to sustain life and to allow nature to take its course. This distinction has been recognized by many courts. *See, e.g.*, *Thor* v. *Superior Court*, 5 Cal. 4th 725, 741-42, 21 Cal. Rptr. 2d 357, 367, 855 P.2d 375, 385 (1993) (recognizing distinction between rejection of medical intervention which will prolong affliction

and initiation of a course of events aimed at own demise); *In re Estate of Longeway*, 133 Ill.2d 33, 42, 549 N.E.2d 292, 296 (1989) (noting that termination of artificial means of life support does not deprive patient of life; patient's inability to breathe or swallow as a result of his illness is the "ultimate agent of death"); *Superintendent of Belchertown State School* v. *Saikewicz*, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, 426 n.11 (1977) (noting that patient's refusal of treatment does not mean patient has specific intent to die).

Moreover, even assuming *arguendo* that New York's statutes treat similarly situated persons unequally, the court below erroneously concluded that the state lacks a rational basis "related to [a] legitimate state interest" for distinguishing between patients seeking assistance in committing suicide and those seeking to decline or discontinue their current medical treatment. Although, as the court below correctly recognized, the court need only find a "rational basis" for the different treatment in order to sustain the challenged statutes, *amici curiae* respectfully suggest that the state's interests in banning physician-assisted suicide are in fact compelling.

In addition to the compelling state interests articulated in the Attorney General's brief below (*i.e.*, the preservation of life, the prevention of manslaughter and homicide, and the protection of its most vulnerable citizens), the ban on assisted suicide is clearly justified by the unique state interests in regulating the practice of medicine upon its citizens and maintaining the ethical integrity of the medical profession, as well as protecting the medical profession from the unwarranted medical and ethical dilemmas that would surely result if this Court strikes down the prohibition against assisted suicide.

A. New York Has an Interest in Regulating the Physician-Patient Relationship

The regulation of physician-assisted suicide is inextricably intertwined with the State's interest in regulating the physician-patient relationship and maintaining the high ethical

standards of its medical community. It is well settled that states are empowered under their police power to regulate the practice of medicine upon its citizens. *See, e.g.*, *Williamson* v. *Lee Optical Co.*, 348 U.S. 483 (1955); *Damino* v. *O'Neill*, 702 F. Supp. 949 (E.D.N.Y. 1987).

Consistent with its police power, New York's laws against assisted suicide protect the sanctity of the physician-patient relationship from undue influence beyond the professional judgment of the doctor. For example, the New York State Task Force on Life and the Law recently concluded that allowing physicians to assist suicide or directly kill patients would be profoundly dangerous for many patients, especially poor or socially disadvantaged patients, who might feel pressured to request early death. *See When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, May 1994, at pp. 6-8. The Task Force noted that "no matter how carefully any guidelines are framed, assisted suicide . . . will be practiced through the prism of social inequality and bias that characterize the delivery of services in all segments of society, including health care." *Id.*

New York's assisted-suicide ban also serves to maintain the ethical integrity of the medical profession. *See Donaldson* v. *Lungren*, 2 Cal. App.4th 1614, 1620, 4 Cal. Rptr. 2d 59, 62 (Cal. App. 2d Dist. 1992) (maintaining the ethical integrity of the medical profession is a pertinent state interest). Indeed, New York's prohibition against physician assisted suicide is consistent with the state's prevailing medical ethical standards.[4] As such, the laws against assisted suicide should be

[4] The medical community of New York State has overwhelmingly rejected the practice of assisted suicide. For example, in addition to the recent recommendation against legalizing physician-assisted suicide by The New York State Task Force on Life and the Law, a task force comprising the highest levels of faculty and administration of the University of Rochester Medical Center has unanimously rejected recent proposals that medical professionals should actively assist patients who wish to end their lives. The task force considered and rejected Respondents' arguments in favor of the right they seek to have this Court create. The task

upheld; the ethics of the medical profession have always been and must remain life-oriented.

B. New York Has an Interest in Protecting the Integrity of the Medical Profession

New York State is also justified in banning assisted suicide to protect members of the medical profession from being compelled to kill their patients. The State's interest in protecting its medical professionals has long been recognized by the courts. For example, in *United States* v. *George*, 239 F. Supp. 752 (D. Conn. 1965), the court was confronted with a Jehovah's Witness who had refused blood transfusions for religious reasons. In ordering the transfusions, the court acknowledged the state's interest in protecting the consciences of its medical professionals:

> "In the difficult realm of religious liberty it is often assumed only the religious conscience is imperiled. Here, however, the doctor's conscience and professional oath must also be respected. In the present case the patient voluntarily submitted himself to and insisted upon medical care. Simultaneously he sought to dictate to treating physicians a course of treatment amounting to medical malpractice. To require these doctors to ignore the mandates of their own conscience, even in the name

force's report states: "The act of suicide raises complex psychological, ethical, social and legal issues. Without passing judgment upon these many dimensions of a complex problem, the Task Force does not believe that it is ethical, desirable, or appropriate for members of the healing professions to render assistance to suicide attempts. The historical proscriptions against suicide and euthanasia within the healing professions are very strong. To violate them would risk great harm to the trust and confidence which the public still imposes upon us. If present trends in our society continue, suicide organizations and la[illegible] practitioners may abound, but the healing profession should not participate." *Report of the Task Force of the University of Rochester Medical Center on Practitioner-Assisted Suicide*, January 1994, at p. 2.

> of free exercise, cannot be justified under these circumstances." *Id.* at 754.

Respondents' requested relief, if granted, will necessarily result in severe ethical problems for the overwhelming majority of physicians, who as a matter of conscience will refuse to abide by their patients' "wishes" to be murdered. New York's laws against assisted suicide protect these physicians from the exposure to malpractice liability that would surely result should the court of appeals' decision stand. *See Eichner* v. *Dillon*, 73 A.D.2d 431, 456, 426 N.Y.S.2d 517, 537 (2d Dep't 1980) ("It has also been said that the State has a compelling interest in maintaining the ethical integrity of the medical profession by protecting physicians against the compelled violation of their professional standards and against exposure to the risk of civil or criminal liability"), *aff'd as modified sub nom. Matter of Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, *Storar* v. *Storar*, 454 U.S. 858 (1981); *Application of President & Directors of Georgetown College, Inc.*, 331 F.2d 1000, 1009 (D.C. Cir.) (noting that doctors' choice of either administering blood transfusion or letting patient die in hospital bed exposed them and hospital to risk of civil and criminal liability), *cert. denied*, 377 U.S. 978 (1964); Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 Fordham L. Rev. 1, 29-33 (1975).

C. The Court of Appeals Usurped the Role of the New York Legislature

This Court's established Equal Protection jurisprudence prohibits judicial usurpation of legitimate State legislative power. Where, as here, the State Legislature has exercised its traditional police power to prohibit conduct found to be inimical to its citizens[5], this Court has required Federal judicial

[5] Until the decision of the Second Circuit and that of the Ninth Circuit in *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 (9th Cir. 1996)(en banc), no one would have doubted the power of the several

deference to State law whenever that law has a rational relationship to a matter of legitimate State concern[6]. The expansive reading of the Equal Protection Clause by the court below exceeds the limited judicial power granted by the United States Constitution to the judicial branch.

The New York Court of Appeals, whose Constitution provides more expansive protection of individual liberties than the United States Constitution[7], has repeatedly rejected attempts to restrict the State's interest in preserving life. *Grace Plaza of Great Neck, Inc.* v. *Elbaum*, 82 N.Y.2d 10, 16, 623 N.E.2d 513, 515, 603 N.Y.S.2d 386, 388 (1993) ("Though our rule reserving the right to the patient is more inflexible than that followed by most of our sister States, it is within the power of the individual States to adopt such a rule and also to higher standards of proof for determining the wishes of incompetent persons than for determining the wishes of those who are competent"); *see also Matter of Storar*, 52 N.Y.2d 363, 438 N.Y.S.2d 266, 420 N.E.2d 64 (1981), *cert. denied*,

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States to protect the lives of citizens by prohibiting conduct which has been the subject of criminal prohibition since the time of adoption of the Fourteenth Amendment. As this Court recognized in *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261, 280-81 (1990):

> "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide. We do not think a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." (Footnote omitted.)

[6] *See, e.g. United States* v. *Lopez*, ___ U.S. ___, 115 S. Ct. 1624 (1995); *Heller* v. *Doe*, 509 U.S. 312 (1993); *City of Dallas* v. *Stanglin*, 490 U.S. 19 (1989); *Kovacs* v. *Cooper*, 336 U.S. 77 (1949); *McNaughton* v. *Johnson*, 242 U.S. 344 (1917); *Murphy* v. *California*, 225 U.S. 623 (1912); *Welch* v. *Swasey*, 214 U.S. 91, 29 S. Ct. 567, 53 L. Ed. 923 (1909).

[7] *See, e.g., People* v. *Scott*, 79 N.Y.2d 474, 490-91, 593 N.E.2d 1328, 1337-38, 583 N.Y.S.2d 920 (1992), and cases cited therein.

454 U.S. 858 (1981); *Matter of Westchester County Medical Center on behalf of O'Connor*, 72 N.Y.2d 517, 531 N.E.2d 607, 534 N.Y.S.2d 886 (1988). These are judgments properly left under the United States Constitution to the political process in the several States. In the absence of a clear restriction on a fundamental constitutional right the federal courts lack the power to interfere in these judgments. What the Second Circuit did here usurped the judgment of generations of duly-elected members of the New York Legislature and effectively disenfranchised the citizens of New York.

II.

THE DECISION OF THE COURT OF APPEALS PROCEEDS UPON A FUNDAMENTALLY ERRONEOUS ASSUMPTION AS TO THE RELATIONSHIP BETWEEN PAINFUL TERMINAL ILLNESS AND THE PATIENT'S DESIRE FOR PHYSICIAN-ASSISTED SUICIDE

As is true for most of the non-medical experts involved in the public debate on physician-assisted suicide, the court below appears to accept the premise that terminally ill patients suffering unremitting pain are most likely to desire to end their life or seek physician assistance with respect thereto:

> "And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life,' *Planned Parenthood* v. *Casey*, 505 U.S. 833, 112 S. Ct. 2791, 2807, 120 L. Ed. 2d 674 (1992), when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness?" 80 F.3d at 730..

The court's emotive appeal to the public's fear of pain and suffering at the end of life is obvious. But it is submitted that the visceral logic involved is fatally flawed when measured against the evidence of what actually happens among terminally ill patients with unremitting pain.

A very recent study of attitudes toward euthanasia and physician-assisted suicide among terminal cancer patients, oncologists and the general public presents a remarkably different picture than that invoked by the court below:

> "One of our most striking findings is that patients who had seriously considered and prepared for euthanasia or physician-assisted suicide were significantly more likely to be depressed. Depressed patients were more likely than non-depressed patients to find that discussions of euthanasia or physician-assisted suicide increased trust in their physician. This finding does not imply that every patient who wants euthanasia or physician-assisted suicide is depressed. Nevertheless, these data, combined with studies on suicidal thoughts among patients with cancer and refusal of life-sustaining treatment among AIDS patients, imply that interest in and actions relating to ending life among patients with life-threatening illnesses are frequently associated with depression and psychological distress.
>
> "Patients experiencing pain were not inclined to euthanasia or physician-assisted suicide. This finding is consistent with data from the Netherlands demonstrating that pain was the only reason for euthanasia in just 10% of cases and a contributing factor in fewer than 50% of cases. It is also consistent with data from American physicians who had carried out euthanasia. The lack of interest in euthanasia or physician-assisted suicide among patients with pain may contribute to oncologists' opposition to these interventions and their sense that discussions of them will reduce patient trust. The results

> suggest that having pain does not predispose a person to desire or take actions to end his or her life. Patients with pain do not seem to view euthanasia or physician-assisted suicide as the appropriate response to poor pain management. Indeed, oncology patients in pain may be suspicious that if euthanasia or physician-assisted suicide are legalised, the medical care system may not focus sufficient resources on provision of pain relief and palliative care.
>
> "These data indicate a conflict between attitudes and probable practices related to euthanasia and physician-assisted suicide. The interventions were approved of for terminally ill patients with unremitting pain, but these are not the patients most likely to request such interventions. This discrepancy between attitudes and likely practices warrants a critical re-examination of the purpose and probable use of euthanasia or physician-assisted suicide." (Footnotes omitted)

Emanuel, Fairclough, Daniels and Clarridge, *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences Among Oncology Patients, Oncologists, and the Public*, Lancet 1996; 347 (9018): 1805-1810 (June 29, 1996), at pp. 14-15.

The above study strongly supports this Court's repeated admonitions to the federal courts to avoid usurpation of the exercise by the States of classic police powers to safeguard the lives and welfare of their citizens. There is no conceivable justification for the decision of the court below to impose its uninformed lay judgment on an issue which the New York Legislature and Executive are competent to and have addressed as recently as 1994.

III.

THE CONSTITUTION IS NOT THE SOURCE OF OUR FUNDAMENTAL HUMAN RIGHTS

There is an even more fundamental error in the approach of the court below—acceptance of the twentieth century judicial theory which posits that fundamental rights are found in the Constitution and are, therefore, subject to "discovery" or "elucidation" within the four corners of the Constitution itself. The political history of our country makes clear that a fundamental idea which united the otherwise disparate individuals who signed the Declaration of Independence was a rejection of the political notion that the King was the source of all individual rights (see Magna Carta). Rather, although there was a deep disagreement as to the form of government which should be formed to protect those rights, there was agreement that the rights themselves inhered in each individual and any form of government which violated those rights was illegitimate and could be overthrown, by force if necessary. This truly revolutionary idea found support in the foundational concept that the source of individual rights could not be any governmental authority, be it King or Parliament, nor any positive law or constitution. Only by accepting this concept could the signers of the Declaration legitimize their decision to sever ties with England by force of arms, which *de facto* was already under way, at least in the northern colonies.

The English philosopher whose work stands most behind the Framers of the Declaration of Independence was, as is well known, John Locke.[8] Locke's *Second Treatise of Government* is most relevant here; scholars of the Revolution gen-

[8] "[T]he great virtuosi of the American Enlightenment—Franklin, Adams, Jefferson—cited the classical Enlightenment texts . . . . In pamphlet after pamphlet the American writers cited Locke on natural rights and on the social and governmental contract." BERNARD BAILYN, THE IDEOLOGICAL ORIGINS OF THE AMERICAN REVOLUTION 27 (1967).

erally have agreed that it is this work which influenced Jefferson the most in drafting the Declaration of Independence.[9] When Jefferson wrote that "all men . . . are endowed by their Creator with certain inalienable rights, that among these are life, liberty, and the pursuit of happiness," it seems plain that Locke was his source, "but Jefferson, as is well known, departed from Locke's trinity of 'life, liberty, and estate' and substituted 'the pursuit of happiness' for the third of these."[10]

To understand what Jefferson meant by inalienable rights to life and liberty, it is useful to look to the *Second Treatise*, where Locke, in his chapter on "The State of Nature," observes:

> "though this be a State of Liberty, yet it is not a State of License, though Man in that State have an uncontrollable Liberty, to dispose of his Person or Possessions, yet he has not liberty to destroy himself, or so much as any Creature in his Possession, but where some nobler use, than its bare Preservation calls for it. . . . Every one as he is bound to preserve himself, and not to quit his Station wilfully; so by the like reason when his own Preservation comes not in competition, ought he, as much as he can, to preserve the rest of Mankind, and may not unless it be to do Justice on an Offender, take away, or impair the life, or what tends to the Preservation of the Life, the Liberty, Health, Limb or Goods of another."[11]

Later in the *Second Treatise* Locke returns to the theme that "a Man" does not have "the Power of his own Life":

[9] "That the central argument of the Declaration is based mainly upon John Locke's *Second Treatise* is indisputable." Forrest Macdonald, Preface to *Novus Ordo Seclorum* ix (1985).

[10] *Id.* at ix.

[11] John Locke, *Two Treatises on Government*, Second Treatise, at 270-71.

> "This Freedom from Absolute, Arbitrary Power, is so necessary to, and closely joyned with a Man's Preservation, that he cannot part with it, but by what forfeits his Preservation and Life together. For a Man, not having the Power of his own Life, cannot, by Compact, or his own Consent, enslave himself to any one, nor put himself under the Absolute, Arbitrary Power of another, to take away his Life, when he pleases. No body can give more Power than he has himself; and he that cannot take away his own Life, cannot give another Power over it."[12]

Locke's firmly repeated anti-suicide theme expressed in another way—one more familiar to Americans—is that these rights are "inalienable"—*i.e.*, Jefferson's formulation is an expression of the demands of Locke's theory of natural rights.

This generally accepted understanding of the source of individual human rights and the function of the Constitution in protecting those rights somehow has been lost. As a result, we have reached a stage where the Constitution has been enshrined as the source of all individual human rights, thus permitting imperfect men and women, appointed to the federal judiciary for life, to "find" in the Constitution new rights as their individual vision of the good of the Nation informs them. This is, however, precisely the sort of unfettered power that the Founders sought to avoid granting to any governmental authority.

The impact of this flawed constitutional vision has been and continues to be the acceptance, even by jurists who purport to reject so-called "judicial activism" in favor of "strict construction" or "original intent," of the notion that the political compromise that was and is the Constitution, is the document to which the Nation must look as the source of individual rights. However, the authors of the Constitution had a much more limited view of their purpose, as the Preamble makes clear:

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12 *Id.*, Chapter IV, Sec. 23, at 284.

> "We the people of the United States, in order to form a more perfect union, establish Justice, insure domestic Tranquility, provide for the common defense, promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity . . . ."

As a consequence, this Court—a creature of the very Constitution it interprets[13]—has in its history gotten things very wrong indeed. A glaring example, but far from the only one, is *Scott* v. *Sandford*, 60 U.S. (19 How.) 393 (1856), in which Chief Justice Roger Taney and the majority of his cool and rational brethren held that Dred Scott, a black man then residing in Missouri, was and always would be "property" without the constitutional right to challenge his being dragged back into slavery with his family by his owner pursuant to the Fugitive Slave Act. Mr. Scott was no less a human person in 1856 than he was after the Emancipation Proclamation, and the Fugitive Slave Act of 1850, Ch 60, 9 Stat. 462 (1850), was never a law to which any citizen was morally compelled to adhere, Congress and the Supreme Court notwithstanding. *See, e.g.*, Michael Stokes Paulsen, *Captain James T. Kirk and the Enterprise of Constitutional Interpretation: Some Modest Proposals from the Twenty-Third Century*, 59 Albany L. Rev. 671, 687-89 (1995).

An apt statement of the jurisprudential approach which could have served to avoid the lurid spectacle of the *Scott* decision is that of Justice Stephen Johnson Field, a former member of the California Legislature, in his dissent in *Powell* v. *Pennsylvania*, 127 U.S. 678, 692 (1888):

> "With the gift of life there necessarily goes to every one the right to do all such acts, and follow all such pursuits, not inconsistent with the equal rights of others, as may support life and add to the happiness of its possessor.

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13 *See* U.S. Const. art. III, § 1 ("The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish").

> The right to pursue one's happiness is placed by the Declaration of Independence among the inalienable rights of man, with which all men are endowed, not by the grace of emperors or kings, or by the force of legislative or constitutional enactments, but by their Creator; and to secure them, not to grant them, governments are instituted among men."

To the same effect is Justice Field's concurring opinion in *Butchers' Union Slaughter-House & Live-stock Landing Co.* v. *Crescent City Live-Stock Landing & Slaughter-House Co.*, 111 U.S. 746, 756-67 (1884):

> "As in our intercourse with our fellow-man certain principles of morality are assumed to exist, without which society would be impossible, so certain inherent rights lie at the foundation of all action, and upon a recognition of them alone can free institutions be maintained. These inherent rights have never been more happily expressed than in the Declaration of Independence, that new evangel of liberty to the people: 'We hold these truths to be self-evident'—that is so plain that their truth is recognized upon their mere statement—'that all men are endowed'—not by edicts of Emperors, or decrees of Parliament, or acts of Congress, but 'by their Creator with certain inalienable rights'—that is, rights which cannot be bartered away, or given away, or taken away except in punishment for crime—"and that among these are life, liberty, and the pursuit of happiness, and to secure these'—not grant them but secure them—'governments are instituted among men, deriving their just powers from the consent of the governed.' "

It was to such principles of natural rights that Justice Curtis also appealed in his dissenting opinion in *Scott* v. *Sandford*, *supra*, 60 U.S. at 624 ("Slavery, being contrary to natural right, is created only by municipal law").

In the Twentieth Century one most often finds these principles expressed in the dissenting opinions of this Court. *See, e.g.*, Justice Marshall's dissent in *Massachusetts Board of Retirement* v. *Murgia*, 427 U.S. 307, 322 (1976):

> "Whether 'fundamental' or not, ' "the right of an individual . . . to engage in any of the common occupations of life" ' has been repeatedly recognized by this Court as falling within the concept of liberty guaranteed by the Fourteenth Amendment. . . . As long ago as *Butchers' Union Co.* v. *Crescent City Co.*, 111 U.S. 746, 4 S.Ct. 652, 28 L.Ed. 585 (1884), Mr. Justice Bradley wrote that this right 'is an inalienable right; it was formulated as such under the phrase "pursuit of happiness" in the declaration of independence . . . . This right is a large ingredient in the civil liberty of the citizen." *Id.*, at 762, 4 S.Ct., at 657 (concurring opinion)."

See also Justice Ginsburg's dissent in *Sandin* v. *Conner*, ___ U.S. ___, 115 S. Ct. 2293 (1995):

> "I see the Due Process Clause itself, not Hawaii's prison code, as the well-spring of the protection due Conner. Deriving protected liberty interests from mandatory language in local prison codes would make of the fundamental right something more in certain States, something less in others. Liberty that may vary from Ossining, New York, to San Quentin, California, does not resemble the "Liberty" enshrined among 'unalienable Rights' with which all persons are 'endowed by their Creator." Declaration of Independence; *see Meachum* [v. *Spano*], 427 U.S. 215, at 230, 96 S.Ct. [2532], at 2541 (STEVENS, J., dissenting) ('[T]he Due Process Clause protects [the unalienable liberty recognized in the Declaration of Independence] rather than the particular rights or privileges conferred by specific laws or regulations.')."

Nevertheless, these first principles are an essential starting point for any reasonable attempt to articulate a rights-based

constitutional jurisprudence, and without them "rights" become, in Mr. Dumpty's words, whatever the speaker says they mean.

Thus, our history teaches that whenever the federal Judiciary, at the height of their assumed powers, ignore the true source of the rights guaranteed by the Constitution, the result is inevitably a disaster. In addition to the obvious example of *Scott* v. *Sandford*, *supra*, numerous other judicial *bete noirs* may be recounted. In each such instance, application of the constitutional jurisprudence suggested herein could have avoided the heinous result. For example, in *Plessy* v. *Ferguson*, 163 U.S. 537 (1896), the Court upheld a Louisiana law requiring "separate but equal" intrastate railroad coaches, and thus permitted legislated public racial discrimination to persist half a century until *Brown* v. *Board of Education*, 347 U.S. 483 (1954) explicitly put an end to the fraudulent "separate but equal" doctrine.

We also seem too ready to forget that prior to the Nineteenth Amendment, women were denied the right to vote (and, often, other fundamental rights), despite the enactment of the Fourteenth Amendment. *See, e.g.*, *United States* v. *Anthony*, 24 F. Cas. 829 (C.C. N.D.N.Y. 1873), upholding the criminal conviction of Susan B. Anthony for the federal crime of voting in a Congressional election in 1872 in New York. In that case, Circuit Justice Hunt wrote:

> "The right of voting, or the privilege of voting, is a right or privilege arising under the constitution of the state, and not under the constitution of the United States. . . . If the state of New York should provide that no person should vote until he had reached the age of thirty years, or after he had reached the age of fifty, or that no person having gray hair, or had not the use of all his limbs, should be entitled to vote, I do not see how it could be held to be a violation of any right derived or held under the constitution of the United States." 24 F. Cas. at 830.

During the same period, the Supreme Court, forgetting the lesson of *Scott* v. *Sandford*, twice upheld the denial of fundamental rights to women, thus demonstrating a social blindness that it took the First World War to remedy. *Bradwell* v. *Illinois*, 83 U.S. (16 Wall.) 130 (1873) (holding that the Fourteenth Amendment did not entitle a woman to admission to practice as an attorney in Illinois); *Minor* v. *Happersett*, 88 U.S. (21 Wall.) 162 (1875) (unanimously upholding denial of registration to vote in the 1872 general election to a Missouri woman). The very fact that these rulings today make us properly uncomfortable strongly counsels against the sort of judicial law-making engaged in by the court below.

Nor are such events confined to the Nineteenth Century. Consider the spectacle of a majority of this Court upholding the criminal conviction of a loyal native-born American citizen of Japanese ancestry for the "crime" of failing to leave his home in California in violation of an evacuation order of the local military commander directed only to Americans of Japanese ancestry. *Korematsu* v. *United States*, 323 U.S. 214 (1944). Justice Murphy's dissent is a powerful indictment of this modern failure to apply a proper constitutional analysis:

> "I dissent, therefore, from this legalization of racism. Racial discrimination in any form and in any degree has no justifiable part whatever in our democratic way of life. It is unattractive in any setting but it is utterly revolting among a free people who have embraced the principles set forth in the Constitution of the United States. All residents of this nation are kin in some way by blood or culture to a foreign land. Yet they are primarily and necessarily a part of the new and distinct civilization of the United States. They must accordingly be treated at all times as the heirs of the American experi-

ment and as entitled to all the rights and freedoms guaranteed by the Constitution." 323 U.S. at 242.

The decision of the court below blatantly substitutes the personal views of three federal judges for the deliberations of elective members of New York's Legislature for over two decades—

> "At oral argument and in its brief, the state's contention has been that its principal interest is in preserving the life of all its citizens at all times and under all conditions. But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. . . . And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life,' . . . , when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: 'None.' " 80 F.3d at 729-30 (Citations omitted).

A more obvious example of impermissible judicial law-making cannot be imagined. There is no fundamental right or suspect classification involved in New York's long-standing penal prohibition against assisted suicide. The New York Executive Branch appointed a blue-ribbon panel which investigated and reported on this very question in 1994. The New York State Task Force On Life and the Law concluded that no exception to the penal law against assisted suicide should be made for physicians requested by competent terminally ill adults to end their life. As is proper in the political process, the broad-based Task Force considered the moral, regulatory and political ramifications of the issue in the context of the conditions actually

prevailing in the State of New York at the end of the Twentieth Century. There is neither constitutional power nor warrant for usurpation of this process by the federal judiciary. This Court must reverse the pernicious denial of the right of the citizens of New York to have their will, as expressed for over two hundred years through their duly-elected legislative representatives, respected by the federal judiciary.

CONCLUSION

The decision of the Court of Appeals should be reversed.

Respectfully submitted,

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF *AMICI CURIAE* OF THE UNITED STATES CATHOLIC CONFERENCE; NEW YORK CATHOLIC CONFERENCE; WASHINGTON STATE CATHOLIC CONFERENCE; OREGON CATHOLIC CONFERENCE; CALIFORNIA CATHOLIC CONFERENCE; MICHIGAN CATHOLIC CONFERENCE; CHRISTIAN LIFE COMMISSION OF THE SOUTHERN BAPTIST CONVENTION; NATIONAL ASSOCIATION OF EVANGELICALS; THE LUTHERAN CHURCH-MISSOURI SYNOD; WISCONSIN EVANGELICAL LUTHERAN SYNOD-LUTHERANS FOR LIFE; THE EVANGELICAL COVENANT CHURCH; AND THE AMERICAN MUSLIM COUNCIL IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF *AMICI*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	5
I. THE NEW YORK HOMICIDE LAWS COMPLY WITH THE EQUAL PROTECTION CLAUSE BECAUSE THEY APPLY EQUALLY TO EVERYONE	5
II. EVEN IF THE EQUAL PROTECTION CLAUSE WERE IMPLICATED, THERE IS A PROFOUND DISTINCTION BETWEEN WITHDRAWING MEDICAL TREATMENT AND ASSISTING IN A SUICIDE	7
A. Assisted Suicide Does Not Implicate the Interest in Being Free of Bodily Invasion	11
B. Assisted Suicide Has Consistently Been Treated as a Criminal Offense Under English and American Law	14
C. In an Assisted Suicide, Death Does Not Result From Natural Causes	15
D. Assisted Suicide Involves an Intention to Cause Death	19
III. NEW YORK HAS A RATIONAL BASIS FOR APPLYING ITS UNIFORM PROHIBITION OF ASSISTED SUICIDE TO PERSONS WHO ARE TERMINALLY ILL	23
CONCLUSION	30

TABLE OF AUTHORITIES

CASES: Page

Barber v. Superior Court, 195 Cal. Rptr. 484 (Cal. App. 1983) 8
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TABLE OF AUTHORITIES—Continued

Page

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McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990) 17
New York City Transit Authority v. Beazer, 440 U.S. 568 (1979) 5
Pratt v. Davis, 79 N.E. 562 (Ill. 1906) 13, 14
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Rochin v. California, 342 U.S. 165 (1952) 12
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	Page
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	Page
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	Page
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INTEREST OF *AMICI*

In this extraordinary case, this Court must decide whether, consistent with the Equal Protection Clause, New York may apply its laws against assisted suicide equally to everyone, including physicians who provide persons in the final stages of a terminal illness with lethal drugs to commit suicide. The Court below held it may not, resting its opinion on an erroneous construction of the Equal Protection Clause, New York law, and medical evidence. Representatives of diverse religious communities, *amici curiae* here, share grave concerns about these unprecedented conclusions. As New York law and medical practices recognize, there is a great difference between letting nature take its course for a gravely ill patient, and intervening in that course by intentionally providing a lethal agent to cause death. All citizens are entitled to laws that protect their lives, even from those who may wish to "assist" their suicides. The common good of our society requires that the life of each person be treated as having inherent worth. Individual statements of interest follow.

The United States Catholic Conference is a nonprofit corporation organized under the laws of the District of Columbia. Its members are the active Roman Catholic Bishops in the United States. The Catholic Bishops of New York, Washington, Oregon, California, and Michigan are, in addition, members of the State Catholic Conferences of those respective states. The Conferences are vehicles through which the Bishops speak cooperatively and collegially on matters affecting the Catholic Church and its people. Roman Catholicism is the largest religious denomination in the United States, with over 60 million members in this country. The Conferences advocate and promote the pastoral teaching of the Church on diverse issues, including the protection of human rights and the sanctity and dignity of human life. Each Conference has been active in supporting state laws that protect persons from assisted suicide.

The Christian Life Commission is the moral concerns and public policy agency for the Southern Baptist Convention, the nation's largest Protestant denomination, with over 15.2 million members in over 38,000 autonomous local churches. The Commission is charged with addressing public policies affecting the sanctity of human life.

The National Association of Evangelicals ("NAE") is a nonprofit association of evangelical Christian denominations, churches, organizations, institutions and individuals. It includes some 42,500 churches from 75 denominations, and 300 parachurch ministries. NAE has joined in this and many other *amicus* briefs in the defense of human rights, including the right to life.

The Lutheran Church-Missouri Synod is the second-largest Lutheran denomination in the United States. It has about 6,000 member congregations and about 2.6 million individual members. In 1995, as a result of their deeply-held religious beliefs on the sanctity of life, the congregations of the Synod passed a resolution expressing the Synod's objection "to medical personnel having any part in actively inducing death, even at the patient's request." The Synod resolved "to speak against any attempt to legalize physician-assisted suicide."

The Wisconsin Evangelical Lutheran Synod-Lutherans for Life is a para-synod organization in fellowship with the 400,000 member Wisconsin Evangelical Lutheran Synod ("WELS") and the 10,000 member Evangelical Lutheran Synod. WELS-Lutherans for Life is a specialized ministry seeking to make known God's will on life and to provide assistance to others on life issues. God's will concerning euthanasia and suicide is clear, recognizing that God acknowledges the absolute value of human life despite its varying or diminished quality. WELS-Lutherans for Life stands by the conviction that it is contrary to the will of God to take one's own life or to assist in such a task.

The Evangelical Covenant Church ("ECC") is a Protestant denomination with 92,000 members in 600 churches

throughout the United States. It operates a university, two hospitals, twelve continuing care retirement communities, and twelve nursing homes as a Christian ministry. ECC has adopted an ethical guideline on death and euthanasia. The guideline affirms the ECC's commitment to provide "the best palliative measures we can to relieve the pain, discomfort and suffering of our patients. . . . We do not act in any way intentionally to cause, assist, or accelerate the death of patients."

The American Muslim Council ("AMC") is a nationally recognized organization representing the interests of the American Muslim community. AMC is a committed advocate of human rights. It participates in interfaith and multiethnic dialogue with the hope of promoting an environment in which tolerance and justice will thrive. AMC's opposition to assisted suicide is rooted in Islamic belief, which strongly affirms the sanctity of human life.

Through their counsel, the parties have consented to the appearance of these *amici*.

SUMMARY OF ARGUMENT

In this case, this Court is asked to reverse an extraordinary ruling—that "terminally ill persons" in the "final stages of dying," as a class, constitutionally must be *excluded* from the mandatory protection of generally applicable homicide laws. This conclusion contravenes the very principle of equal protection under law upon which the Second Circuit below purported to ground its decision. Excluding people from the protection of the homicide laws based on the condition of their health is a particularly serious departure from the principle of equal justice for all. It is a grave injustice to deprive any person of the protections against deadly harm that are extended to all others under the criminal law. Indeed, withholding such protections is an injustice of unspeakable magnitude, for it leads to the literal destruction of the very lives that government is charged with protecting.

The decision below is based on at least five erroneous assertions. First, the court erred by subjecting to equal

protection scrutiny New York homicide laws that create no classification whatsoever. Second, contrary to this Court's declaration that the Equal Protection Clause is not a source of substantive rights, the court below created a new "right to hasten death" that has never been recognized by the New York legislature or New York courts. Third, disregarding precedent and common sense, the court erroneously declared that there is no rational difference between complying with a person's decision to decline medical treatment and providing that person with a lethal poison to commit suicide. Fourth, disregarding this Court's own admonitions, the court below incorrectly found that New York has a "greatly reduced" interest in protecting the lives of persons who are in the "final stages of a terminal illness," thereby removing this ambiguously-defined and vulnerable class of persons from the protections of an unambiguous and generally applicable homicide statute. Fifth, by concluding that persons who fall within this ambiguous category can choose only between self-destruction or continued "agony," the court erroneously suggested, as a matter of law and for the entire Nation, that this class of citizens is simply and unalterably beyond the reach of modern-day medical and palliative care—a suggestion that is as false as it is cynical.

This case is not about respecting a person's desire to be free of an unwanted or burdensome medical treatment. It is about providing those who appear to be terminally ill with a death-producing agent for the express purpose of causing their death. The Second Circuit erroneously concluded that the Constitution forbids States to recognize a difference between the two. The court thus cast aside as "irrational" a distinction that has achieved nearly universal recognition in the common law, statutory law, the medical profession, and countless court decisions, including the law of New York. A 1994 Task Force appointed by the Governor of New York cited the distinction between declining medical treatment and administering a lethal agent with the intentional purpose of causing death, as one of many reasons for retaining the State's

laws prohibiting assisted suicide. On this basis, the New York legislature acted reasonably in leaving its law unchanged.

In the last analysis, the ruling below manufactures a "right" that would radically alter society. The rule of law reflects the idea of "ordered liberty." There is no right for one person to provide another with the means of taking his or her life. The decision below must be reversed.

ARGUMENT

This Term, the Court confronts what, without exaggeration, may be the most profound and far-reaching federal constitutional question ever to have demanded its attention. At issue is whether a centuries-old tradition and prohibition—*we will not take the life of another even if asked*—should be abandoned. No departure from that proscription should be allowed by this Court. Indeed, the very uniformity of that tradition suggests a serious and fundamental error at the heart of the lower court's analysis.[1]

I. THE NEW YORK HOMICIDE LAWS COMPLY WITH THE EQUAL PROTECTION CLAUSE BECAUSE THEY APPLY EQUALLY TO EVERYONE.

The New York homicide statutes struck down in this case create no classifications whatsoever. In New York, no one may assist another person to commit suicide or obtain another person's "assistance" in committing suicide. Since the statutory prohibition against assisted suicide applies to everyone equally, it clearly complies with the Equal Protection Clause. *New York City Transit Authority v. Beazer*, 440 U.S. 568, 587 (1979) (laws that apply evenhandedly to all persons "unquestionably comply" with the Equal Protection Clause).

What is more, the Second Circuit's decision *creates* an equal protection problem where none had existed before.

---

[1] This Court has agreed to hear *State of Washington v. Glucksberg*, No. 96-110, raising the same conceptual questions but from a different legal perspective.

The court's conclusion that the Equal Protection Clause requires *unequal* application of a generally applicable criminal law, depending on the health condition of the victim and whether the defendant has a medical license, contradicts the very principle of equal protection upon which the court below purported to ground its decision. It is abhorrent to the principle of equal justice under law to withhold from terminally ill patients "the same protections from suicide the majority enjoys." *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal pending*, No. 95-35804 (9th Cir.) (*sub judice*).

There is a second and equally fundamental problem with the Second Circuit's decision. The court relied upon the Equal Protection Clause to create what it called a "right to hasten death"—a new substantive right that is not recognized by the New York legislature or the New York courts. As this Court has declared, "[i]t is not the province of [the federal courts] to create substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio Independent School District v. Rodriguez*, 411 U.S. 1, 33 (1973). There is, moreover, a contradiction between New York law and this judicially invented "right to die" or "right to hasten death"—a "right" which, stripped of euphemism, would more aptly be called a "right to assisted suicide" because that is the conduct at issue here. The contradiction is obvious: assisted suicide is *proscribed* by the very New York legislature that the Second Circuit claimed had implicitly *created* a "right to hasten death." Conduct cannot be explicitly banned under state criminal law and at the same time constitute a state-created "right" subject to "equal application" under the Equal Protection Clause.[2]

[2] New York law rejecting a "right to hasten death" is clear. *Matter of Storar*, 420 N.E.2d 64, 71 n.6 (N.Y. App.), *cert. denied*, 454 U.S. 858 (1981). But for the Second Circuit's declaration of such a "right," which is contrary to New York's view, there would be no equal protection problem. In *Leavitt v. Jane L.*, 116 S. Ct. 2068 (1996), this Court summarily reversed the Tenth Circuit's invalidation of the entire Utah statute regulating abortion based on the court of appeal's failure to apply a clear legislative severability clause. *Id.* at 2070. By disregarding clear state law and creating the classification, the Second Circuit's action is analogous and calls for the same remedy here. *See id.* at 2073.

For the Second Circuit to declare who may be charged with a homicide in New York and under what circumstances is a radical departure from the proper judicial role. A declaration by a court that assistance in self-destruction is a "benefit" or "right" for one particular class of citizens, while remaining a crime when inflicted upon all other citizens, would be tantamount to deciding that some persons are truly better off dead than alive. How such a mandate could be rooted in the Constitution defies reasoned explanation. Our Constitution does not mandate that state-licensed healing professionals be permitted to assist in the self-destruction of any class of citizens.

II. EVEN IF THE EQUAL PROTECTION CLAUSE WERE IMPLICATED, THERE IS A PROFOUND DISTINCTION BETWEEN WITHDRAWING MEDICAL TREATMENT AND ASSISTING IN A SUICIDE.

The Second Circuit, substituting its judgment for that of the New York legislature, erred by denying that there is any rational difference between assisting a suicide and acceding to a decision to forego medical treatment. The legislature saw the distinction clearly. Under New York law, everyone is permitted to accept or refuse his or her own medical treatment, yet no one is permitted to enlist another person's assistance in committing suicide. *See, e.g., Matter of Storar*, 420 N.E.2d 64, 71 n.6 (N.Y. App.) (distinguishing a natural death from self-inflicted killing), *cert. denied*, 454 U.S. 858 (1981); *id.* at 74 (Jones, J., dissenting) ("I explicitly disclaim any intention, expressly or by implication, to invite consideration of . . . the deliberate use of a life shortening agent for the termination of life").

The distinction between withdrawing treatment and assisting a suicide is supported by both authority and reason. Courts and legislatures, including those of New York, have uniformly and consistently recognized the distinction.[3] When courts began to extend the right to forego treatment to incompetent and comatose patients, they did so precisely *because* it was different from committing suicide, and they cautioned explicitly that these decisions were not to be taken as blurring or violating that distinction. *Matter of Quinlan*, 355 A.2d 647, 665 (N.J. 1976) ("We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support"), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976). The difference between foregoing treatment and assisting

[3] *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Cal. App. 1983) ("Euthanasia, of course, is neither justifiable nor excusable in California"); *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (distinguishing a "competent, rational decision to refuse treatment when death is inevitable" from an act of intentional self-destruction); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225-26 (Cal. App. 1984) (suicide is distinguishable from death from natural causes which results from disconnecting a respirator from a comatose, terminally ill patient); *Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (declining life-sustaining medical treatment is distinguishable from suicide because it "merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury"); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Cal. App. 1986) (a "decision to allow nature to take its course is not equivalent to an election to commit suicide with . . . parties aiding and abetting therein"); *Brophy v. New England Sinai Hospital*, 497 N.E.2d 626, 635 n.29, 638 (Mass. 1986) ("the law does not permit suicide," which is distinguishable from the decision to remove life-sustaining treatment from a patient who is in a persistent vegetative state and unlikely to regain cognitive functioning); *Donaldson v. Van de Kamp*, 4 Cal.Rptr.2d 59, 63 (Cal. App. 1992) ("Here there are no life-prolonging measures to be discontinued. Instead, a third person will simply kill [the plaintiff]"). *See also* Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Oregon L. Rev. 449, 465-66 n.59 (1995) (citing additional cases).

suicide is explicitly recognized by 45 state legislatures, including New York, and the District of Columbia, in the living will and power of attorney laws of these jurisdictions.[4]

The American Medical Association ("AMA") likewise recognizes a "fundamental difference between refusing life-sustaining treatment and demanding a life-ending treatment." AMA Council on Ethical and Judicial Affairs, *Report I-93-8*, at 2.[5] So do other medical associations.[6] To state the AMA position:

> When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease. The illness is simply allowed to take its natural course. With assisted suicide, however, death is hastened by the taking of a lethal drug or other agent. Although a physician cannot force a patient to accept a treatment against the patient's will, even if the treatment is life-sustaining, it does not follow

[4] Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Oregon L. Rev. at 462-3 (listing statutes).

[5] Individual health care professionals understand the difference as well, with 87% of physicians and nurses in a recent study agreeing that "to allow patients to die by forgoing or stopping treatment is ethically different from assisting in their suicide." Mildred Z. Solomon, *et al., Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. of Pub. Health 14, 17-18 (Jan. 1993).

[6] The World Medical Association, American Nurses Association, National Hospice Organization, American Geriatrics Society, Canadian Medical Association, and British Medical Association oppose physician-assisted suicide. Edward R. Grant & Paul Benjamin Linton, *Relief or Reproach?: Euthanasia Rights in the Wake of Measure 16*, 74 Oregon L. Rev. at 469 n.70; Leah L. Curtin, *Nurses Take a Stand on Assisted Suicide*, 26 Nursing Management 71 (May 1995); Bill Wallace, *The Right to Die Rightly*, 3 Hospice 10-11, 28 (Summer 1992). According to the National Hospice Organization's position statement: "Euthanasia is different in kind, not degree, from treatments that allow death to occur or even those which unintentionally hasten it." Wallace, *supra* at 11.

> that a physician ought to provide a lethal agent to the patient. The inability of physicians to prevent death does not imply that physicians are free to help cause death.

Id. The Second Circuit's elimination of this distinction therefore overrides not only a legislative judgment but the medical profession's own longstanding ethical judgment, thus undermining the profession's "unqualified opposition to physician-assisted suicide." Brian McCormick, *Continued Opposition: House Refuses to Open Door on Physician-Assisted Suicide*, Am. Med. News, Dec. 20, 1993, at 7; American Medical Association Press Release, "AMA Soundly Reaffirms Policy Opposing Physician-Assisted Suicide" (June 25, 1996).

The American Bar Association's Commission on Legal Problems of the Elderly also recognizes that decisions to refuse treatment are "legally and ethically distinct" from decisions to provide "a lethal agent with the intentional purpose of terminating life." American Bar Association ("ABA"), Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues in Law & Med. 117, 118 (Summer 1992). Assisted suicide, as one commentator on the law has observed, "involves not letting the patient die, but making the patient die. . . ." Stephen L. Carter, The Culture of Disbelief 236 (1993).[7]

Like the AMA, ABA, and countless courts, New York knows (and argued below) that there is a material difference between declining medical treatment and assisting a suicide. In 1994, a 25-member Task Force on Life and the Law appointed by the Governor of New York concluded that the distinction was one of many reasons for retaining the existing New York ban on assisted suicide. The Task Force wrote:

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[7] *See also* Robert Byrn, *Compulsory Lifesaving Treatment for the Competent Adult*, 44 Fordham L. Rev. 1 (1975) ("suicide means something quite different in the law" from refusing lifesaving treatment).

> As . . . courts have recognized, the fact that the refusal of treatment and suicide may both lead to death does not mean that they implicate identical constitutional concerns. The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent with society's basic conception of personal dignity. . . . It is this right against intrusion—*not a general right to control the timing and manner of death*—that forms the basis of the constitutional right to refuse life-sustaining treatment. Restrictions on suicide, by contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.

New York State Task Force on Life and the Law, When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context 71 (1994) (emphasis added).

The distinction between declining treatment and assisting suicide is likewise supported by reason. There are at least four critical differences. Assisted suicide (1) does not implicate the interest in being free of bodily invasion, an interest that is central to the refusal of medical treatment, (2) has been consistently criminalized under the common law and by statute, (3) does not involve death from natural causes, and (4) involves a direct and unambiguous intention to cause death. *Any one of these differences is sufficient* to demonstrate the rationality of the distinction.

A. Assisted Suicide Does Not Implicate the Interest in Being Free of Bodily Invasion.

The interest of a competent adult in being free of bodily invasion at the hands of another has been a mainstay of English and American law for centuries. The law protects this interest by imposing a duty upon everyone to refrain even from touching another, absent his or her consent. Doctors who violate this duty by administering medical treatment to unwilling patients are subject to civil damages, even if the treatment might have been thought

beneficial or life-saving to the patient. *E.g., Matter of Storar,* 420 N.E.2d at 71 (New York imposes "civil liability on those who perform medical treatment without consent, although the treatment may be beneficial or even necessary to preserve the patient's life"). An assisted suicide, by contrast, posits a right to *insist* upon a bodily invasion—one so radical that it invariably and deliberately causes death.

It was precisely the interest in being free of bodily invasion—not any right to self-destruction—that was at issue in *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 261 (1990). In deciding that Missouri could require clear and convincing evidence of an incompetent patient's past wishes before allowing the discontinuation of artificially administered nutrition and hydration, this Court observed that a liberty interest "in *refusing unwanted medical treatment* may be inferred from our prior decisions." *Cruzan,* 497 U.S. at 278 (emphasis added); *id.* at 279 (petitioner claimed that "the forced administration of life-sustaining medical treatment . . . would implicate a competent person's liberty interest"); *id.* at 287 (O'Connor, J., concurring) ("I agree that a protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions"). As Justice O'Connor observed, the liberty interest in refusing medical treatment "flows from decisions involving the State's invasions into the body." 497 U.S. at 287 (O'Connor, J., concurring). It was "state incursions into the body," Justice O'Connor wrote, that were repugnant to the Due Process Clause. *Id.*[8] At the same time, this Court recognized that

[8] Other decisions of this Court also recognize the interest in being free of bodily invasion. *Washington v. Harper,* 494 U.S. 210, 221-22 (1990) (liberty interest in avoiding the unwanted administration of anti-psychotic drugs); *Jacobson v. Massachusetts,* 197 U.S. 11, 24-30 (1928) (liberty interest in declining an unwanted smallpox vaccine is outweighed by the common good); *Rochin v. California,* 342 U.S. 165, 172 (1952) ("forcible extraction of . . . stomach's contents" in criminal search offends due process); *Winston v. Lee,* 470 U.S. 753, 759 (1985) ("compelled surgical intrusion into an individual's body for evidence" implicates the Constitution).

> As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide.

Id. at 280. The fact that one may forego medical treatment "even if" treatment might have prolonged life suggests how misleading it is to speak of a "right to die." Patients have a right to refuse treatment *despite* the fact that treatment might have extended their lives, not *because* the refusal will shorten their lives.

The difficulty in speaking of a "right to die" or a "right to hasten death" is also demonstrated by the relation between the principle of informed consent and the overarching aim of tort law to protect people from harm. The principle of informed consent historically provided a remedy for people who were injured when their physicians failed to adequately disclose relevant risks and dangers, or failed to obtain any consent at all, before carrying out a medical procedure. This was the foundation of the common law principle of informed consent.

> Ordinarily, where the patient is in full possession of all his mental faculties and in such physical health as to be able to consult about his condition without the consultation itself being fraught with dangerous consequences to the patient's health, and when no emergency exists making it impracticable to confer with him, it is manifest that his consent should be a prerequisite to a surgical operation.

Pratt v. Davis, 79 N.E. 562, 564 (Ill. 1906). That the principle of informed consent is grounded in concern for the preservation of bodily health is evident from its exceptions. When its application does not serve the goal of preserving life and health, the principle of informed consent may give way to exceptions that will. This occurs,

for example, (1) when, in an emergency, immediate remedial treatment must be undertaken to preserve the patient's life or health and the patient's decision on the treatment cannot be obtained, or (2) when it is apparent that full disclosure regarding the proposed treatment or procedure will only harm the patient's health. *Canterbury v. Spence*, 464 F.2d 772, 788-89 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); *Pratt v. Davis*, 79 N.E. at 564; *see Schloendorff v. Soc. of N.Y. Hosp.*, 105 N.E. 92 (N.Y. 1914). That patients may refuse treatment (over the objection of a physician who believes treatment would be beneficial) is simply a corollary of the rule that the patient has ultimate responsibility to decide the direction of his or her health care. That the power to resolve disagreements about whether to accept health care resides with the patient does not mean that the patient has a constitutional right to obtain from a physician something which is the very antithesis of health care—the means of inflicting deadly self-harm.

B. Assisted Suicide Has Consistently Been Treated as a Criminal Offense Under English and American Law.

As the Second Circuit itself observed, it cannot be said that a right to assisted suicide is rooted in the nation's traditions or history:

> Indeed, the very opposite is true. The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. Clearly, no "right" to assisted suicide ever has been recognized in any state in the United States.

Quill v. Vacco, 80 F.3d 716, 724 (2d Cir. 1996) (citations omitted). Today a "majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan v. Director, Missouri Department of Health*, 497 U.S. at 280. In recent years, in fact, that number has increased. In 1996, Iowa and Rhode Island joined the ranks of states with specific statutes against assisting a suicide.[9] Since 1994, at least seventeen states have considered and rejected proposals to legalize assisted suicide.[10]

"American law has always accorded the State the power to prevent . . . suicide," let alone assisted suicide. *Cruzan*, 497 U.S. at 293 (Scalia, J., concurring). The right to decline medical treatment, by contrast, has a long pedigree in the common law and is recognized in every state.

C. In an Assisted Suicide, Death Does Not Result From Natural Causes.

A patient's death by assisted suicide is caused not by any underlying disease, but by an intervening lethal act.

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[9] Iowa S.F. 2066, to be codified at Iowa Code § 707A.2 (Supp. 1996); R.I. Pub. Act 96-133, to be codified at R.I. Gen. Stat. tit. 11, ch. 60.

[10] Alaska, HB 371 (died in House State Affairs Committee, 1996); Arizona, S.B. 1007 (negative vote in Senate Health Committee, Jan. 1996); California, A. 1080 (withdrawn by sponsor in 1995) and A. 1310 (died without a hearing, Jan. 1996); Colorado, H.B. 1308 (tabled by House Committee on Health, Environment, Welfare and Institutions, Feb. 1995) and H.B. 1185 (defeated 7-to-4 in the same committee, Feb. 1996); Connecticut, S.B. 361 (died in committee, April 1995); Maine, L.D. 748 (rejected by House Judiciary Committee 10-to-3 and by full House 105-to-35, June 1996); Maryland, H.B. 933 (rejected by House Environmental Affairs Committee 15-to-4 in 1995) and H.B. 474 (rejected by same committee 16-to-5 in 1996); Massachusetts, H.B. 3173 (died in House Judiciary Committee, May 1995); Michigan, H.B. 4134 (died in committee, 1995); Mississippi, H.B. 1023 (died in House Judiciary Committee, 1996); Nebraska, L.B. 1259 (died in Judiciary Committee, 1996); New Hampshire, H.B. 339 (rejected by House of Representatives 256-to-90, Jan. 1996); New Mexico, S.B. 446 (tabled 6-to-1 by Senate Judiciary Committee, Feb. 1995); New York, S. 1683, S. 5024-A, A. 6333 (died without a hearing in 1995); Vermont, H.B. 335 (died in House Committee on Health and Welfare, 1995); Washington, S.B. 5596 (died in committee, March 1995); Wisconsin, S.B. 90 and A.B. 174 (died in committee).

If, for example, a doctor does not put a patient on a respirator or feeding tube because the patient has decided to forego such treatment, death may occur if the patient's disease or injury prevents adequate respiration or nutrition. But American courts have long recognized that what impedes the patient's ability to breathe or eat adequately on his or her own is the underlying disease, not an intervening act by the physician.[11]

On this point, the Second Circuit was simply mistaken. It wrote:

> [T]here is nothing "natural" about causing death by means other than the original illness or its complications. The withdrawal of nutrition brings on death by starvation, the withdrawal of hydration brings on death by dehydration, and the withdrawal of ventilation brings about respiratory failure. By ordering the discontinuance of these artificial life-sustaining processes or refusing to accept them in the first place, a patient hastens his death by means that are not natural in any sense. It certainly cannot be said that the death that immediately ensues is the natural result of the progression of the disease or condition from which the patient suffers.

80 F.3d at 729. The court's analysis is faulty and, not surprisingly, the court offered no supporting authority. "Nat-

[11] Again, New York law on this point is clear. *Delio v. Westchester County Medical Center*, 516 N.Y.S.2d 677, 692 (N.Y. S. Ct. 1987) (death following withdrawal of a patient's feeding tube "will be the end result of his inability to chew and swallow spontaneously and not the result of a self-inflicted injury"). *See also Matter of Conroy*, 486 A.2d 1209, 1226 (N.J. 1985) (death following removal of feeding tube "would result, if at all, from [the patient's] underlying medical condition, which included her inability to swallow"); *In re Estate of Longeway*, 549 N.E.2d 292, 296 (Ill. 1989) (withdrawal of feeding tube "does not deprive the patient of life; rather the inability of the patient to chew or swallow, as a result of his illness, is viewed as the ultimate agent of death"); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987) (patient's death following removal of feeding tube is caused by "his accident and his resulting medical condition, including his inability to ingest food and water").

ural" means "produced or existing in nature, not artificial or manufactured." Webster's New World Dictionary 903 (3d College ed. 1988). A respirator or feeding tube is an *artificial* or manufactured device that is intended to overcome a *natural* incapacity to breathe or eat adequately on one's own. Thus, the law recognizes that one who dies because of a natural incapacity to breathe or eat adequately dies of natural causes.

A death that may or may not *follow* after a patient's refusal of ventilator assistance,[12] for example, is plainly different from a death that is *caused* by placing a pillow over a patient's face and deliberately smothering him (even if he consents). The first is natural, for in that case one dies because of a disease or injury that was not brought on by the physician's intervention.[13] Strangling

[12] Of course, death does not always occur following the removal of a respirator or feeding tube. For example, Karen Ann Quinlan lived for nine years after her respirator was removed. Yale Kamisar, *The Real Quinlan Question Lives On*, Minneapolis Star Tribune, June 18, 1985. Likewise, a patient capable of ingesting even small amounts of food or water on his or her own may continue to live. Ronald E. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 Hastings Center Report 27, 28, 31 (Feb./March 1988).

[13] *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) (refusing medical intervention merely allows the disease or effects of an injury to take its natural course); *Matter of Conroy*, 486 A.2d 1209, 1224 (N.J. 1985) (assisted suicide is different from refusing medical intervention because the latter "merely allows the disease to take its natural course"); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 638 (Mass. 1986) (death following refusal of medical intervention "merely allows the disease to take its natural course"); *McConnell v. Beverly Enterprises-Connecticut, Inc.*, 553 A.2d 596, 605 (Conn. 1989) ("death [following removal of feeding tube] will be by natural causes underlying the disease, not by self-inflicted injury"); *Bartling v. Superior Court*, 209 Cal.Rptr. 220, 225 (Cal. App. 1984) (disconnection of respirator merely allows "death by natural causes"); *In re Browning*, 568 So.2d 4, 14 (Fla. 1990) ("suicide is not an issue when . . . the discontinuation of life support 'in fact will merely result in death, if at all, from natural causes'") (citation omitted), *aff'd*, 379 So.2d 359 (Fla. 1980); *Leach v. Akron Gen. Medical Ctr.*, 426 N.E.2d 809, 815 (Ohio Ct.

or poisoning a patient, on the other hand, even if he consents, is not by any means natural. One must therefore reject the Second Circuit's conclusion that withholding or withdrawing medical treatment is an "unnatural" cause of death.

To hold otherwise leads to absurd results. In most cases of illness, some form of modern medical technology could be found which may briefly extend life.[14] If a failure to initiate or continue such technology cannot rationally be distinguished from causing an "unnatural" death, then there is no such thing as death by "natural" causes.[15] Or rather, the *only* "natural" death would be one in which every possible *artificial* life-sustaining treatment was aggressively maintained but unable to delay death.

Common Pleas 1980) ("Withdrawal of a respirator . . . allows the processes of nature to run their course"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("A death which occurs after the removal of life sustaining systems is from natural causes"); *Superintendent of Belchertown v. Saikewicz*, 370 N.E.2d 417, 426 n.11 (Mass. 1977) (in case of withdrawing treatment, "the cause of death [is] from natural causes"); *Matter of Quinlan*, 355 A.2d at 669-70 (death following withdrawal of medical treatment "would not be homicide but rather expiration from existing natural causes").

[14] One commentator has noted that "where humans were once helpless onlookers in the presence of death, we are now increasingly able to intervene in the process, using technological resources to direct or delay the inevitable." Robert M. Veatch, Death, Dying, and the Biological Revolution 2 (Yale Univ. Press. 1989).

[15] The Second Circuit is on solid ground, however, in treating the withholding and withdrawal of treatment as similar. To establish a special obligation to continue treatment once begun would have "serious adverse consequences" for many patients. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions 75 (March 1983). For example, physicians would fail to offer or initiate many potentially beneficial treatments if there were a chance that treatment might later become futile or burdensome, thus placing them in an impossible ethical and legal situation.

D. Assisted Suicide Involves an Intention to Cause Death.

If a patient should die after refusing treatment, the attending physician is not liable for homicide for he or she did not intend death. When a doctor accedes to a patient's request to provide the means of committing suicide, however, death is always the intention. *Matter of Storar*, 420 N.E.2d 64, 71 (N.Y. 1981) (doctor cannot be held criminally liable "when he honors the right of a competent adult patient to decline medical treatment"). The absence of a deadly intention in the former case is most obvious when treatment is merely *withheld* at the patient's request rather than provided to the patient and then later *withdrawn*. In withholding treatment, a physician need not "intend" anything, for he or she has not acted at all, lacking authorization from the patient to do so. His or her intention is simply to respect the patient's informed decision to decline medical treatment, as the physician legally must. But the absence of a deadly intention is also clear when treatment is withdrawn. When, for example, a patient unexpectedly survives following withdrawal of life-sustaining treatment, families and courts do not then seek a way of ensuring the patient's death, for that was not the intention.[16] Rather, the intent was simply to discontinue a treatment considered to be futile, invasive, or burdensome.[17]

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[16] *Karen Ann Quinlan Still Lingers On*, Newsweek, March 3, 1980, at 14 (parents' only intent was to forego one invasive procedure).

[17] By contrast, the intent to ensure death is absolutely clear in assisted suicide. Some proponents, conceding that attempts to commit suicide by orally ingesting drugs may sometimes fail to achieve that result, have declared that the law should also authorize lethal injections so that a physician can always be standing by "to administer the *coup de grace* if necessary." D. Humphry, *Oregon's Assisted Suicide Law Gives No Sure Comfort to Dying*, N.Y. Times, Dec. 3, 1994, at 22 (letter to the editor). The Ninth Circuit accommodated this concern by refusing to find any "principled distinction" between assisted suicide and active euthanasia. *Compassion in Dying v. State of Washington*, 79 F.3d 790, 831 (9th Cir. 1996).

A request to withdraw treatment generally involves a judgment by that patient about the positive and negative effects *of that particular treatment* on that patient in light of his or her ability to benefit from it and endure its burdens. "Both as a matter of law and as a matter of medical ethics, the right to refuse unwanted medical intervention is properly seen not as part of a right to become dead but rather of a *right protecting how we choose to live*, even while we are dying." Leon Kass, *Dehumanization Triumphant*, 65 First Things 16 (August/Sept. 1996). For example, in rejecting a final round of chemotherapy, the effectiveness of which is in doubt, a cancer patient chooses how to spend the rest of his or her life (*e.g.*, in relative comfort, at home with family), not that he or she is better off dead. By contrast, the clear purpose of assisted suicide is to cause the patient's death.

To be sure, there are extreme cases in which a refusal of treatment may seem tantamount to the implementation of a suicidal wish. It is precisely in such cases that the right to refuse treatment reaches its legal and logical limit, as noted by this Court. *Cruzan*, 497 U.S. at 279 (stating that the "dramatic consequences" involved in refusing artificially-delivered nutrition and hydration "would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible").[18] At times such a decision can justify a judgment that the person is not fully competent and requires protection from self-harm. When the malicious intent to cause death is clear, even withdrawal of a respirator may be prosecuted as a

[18] In recent years, an ethical debate has arisen as to whether medically assisted nutrition and hydration is best seen as a form of care generally owed to helpless patients. The Catholic moral tradition, in particular, opposes "euthanasia by omission"—that is, a withdrawal of sustenance or other basic support that disregards the benefits and burdens of a particular procedure and aims simply at ensuring the death of a patient. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 8 (Boston: St. Paul Books 1980).

homicide.[19] But such cases are extreme and rare, and certainly do not render the general distinction between withdrawing treatment and assisting suicide either invalid or irrational. If there is any "twilight" in the category of decisions to decline medical treatment, it should not lead this Court to conclude that there is no difference between the day and night of declining treatment and assisting suicide.

Some argue that assisted suicide is indistinguishable from the depression of respiration that may be a side-effect of large dosages of pain control medication.[20] In fact, when dosages are properly calibrated to relieve pain, this side-effect is extremely rare,[21] if it occurs at all. Those

[19] Linda Miller Terman, *Triple Murderer Gets Death Sentence*, The Washington Times, Oct. 17, 1995, at C3 (man sentenced to death for killing a disabled boy by disconnecting his respirator).

[20] According to the president-elect of the American Academy of Hospice and Palliative Medicine, that assertion is "out of touch with biologic and pharmacologic reality" because morphine given to control pain "simply does not hasten someone's death." Diane M. Gianelli, *Assisted Suicide or Pain Relief?: Recent Court Rulings Discount Age-Old Ethical Distinction*, American Med. News, July 1, 1996, at 3.

[21] "Addiction among patients who receive narcotics for pain is exceedingly unlikely; the incidence is probably no more than 0.1 percent . . . . The incidence of serious respiratory depression in patients who receive narcotics for pain is similarly low. As tolerance develops to the analgesic effects of narcotics, so it does to respiratory effects. No more than 1 percent of patients who receive narcotics for pain develop serious respiratory depression." Marcia Angell, *The Quality of Mercy*, 306 New Eng. J. Med. 99 (Jan. 14, 1982). *See also* American Pain Society, Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain 23 (3d ed. 1992) ("[R]espiratory depression is rare in patients who have been receiving chronic opioid treatment"); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1129 (Oct. 10, 1996) ("Appropriate titration of the opioid dose rarely results in respiratory depression or cardiovascular collapse"); E. Cassidy, *et al.*, *As Life Ends: Professional Care Givers on Terminal Care and Euthanasia*, in I. Gentles, ed., Euthanasia and Assisted Suicide: The Current Debate 52 (Stoddart 1995) ("[I]t is well

very rare cases in which pain medication may risk an earlier death from respiratory depression are distinguishable from assisted suicide because the intent in administering these drugs is not to cause death, but to relieve pain. In the very unlikely event that death may occur, it is an *unintended* consequence, not the intended result. Assisted suicide and euthanasia, on the other hand, involve an intention to cause death. Thus, a doctor who suddenly administers a massive dose of barbiturates with the *intention* of causing death is liable for a homicide.[22] On the other hand, a doctor who administers medication only with the intention of relieving pain and whose conduct is not reckless, would not be liable for a homicide if death occurs any more than he or she would be criminally liable under the same conditions if death resulted from a risky surgery.[23]

The difference between intention and foreseeability is central to our system of criminal and civil law:

> The distinction between what is intended and what is not intended but brought about as a side-effect is

known by practitioners in the field of terminal care that deaths from narcotics are extremely rare in terminal patients").

[22] Michael Berry, *Doctor Found Guilty in Patient's Death*, The Wichita Eagle, Jan. 27, 1996, at 1A; Robert D. McFadden, *Hospital Patient's Fatal Overdose is Ruled a Homicide*, N.Y. Times, July 2, 1993, at B3; *Nurse Pleads Guilty to Killing Three Patients*, N.Y. Times, Apr. 10, 1992, at A23; *Nurse's Death Sentence Upheld*, American Med. News, Sept. 14, 1992, at 2; *Nurse's Aide Gets 20 to 40 Years for Helping Kill Elderly Patients*, The Washington Times, Oct. 2, 1989, at A-7.

[23] This analogy to potentially life-saving surgery is especially valid in light of modern medical knowledge that unrelieved pain can itself weaken a patient and even undermine his or her immune system, thus hastening death. A "new development" in the field of pain management is "the idea of killing pain before it kills the patient." Marsha F. Goldsmith, *Pain Speaking—And Anesthesiologists Answer*, 267 J. of the Am. Medical Association 1578 (March 25, 1992). "Unrelieved agony will shorten a life more surely than adequate doses of morphine." Catholic Health Association, Care of the Dying: A Catholic Perspective 30 (1993).

> at the basis of the vast modern law of tortious liability in negligence; it is the focus, too, of the criminal law's long accepted distinction between murder and manslaughter. As those facts suggest, it is not the esoteric preserve of some sectarian moral teaching, but a morally significant distinction which is intrinsic to practical reasonableness.[24]

The Second Circuit's decision is based on the radical notion that the intended/unintended distinction is not a meaningful one, a notion that this Court should resoundingly reject.

III. NEW YORK HAS A RATIONAL BASIS FOR APPLYING ITS UNIFORM PROHIBITION OF ASSISTED SUICIDE TO PERSONS WHO ARE TERMINALLY ILL.

New York acted rationally in prohibiting assisted suicide for persons in the final stages of a terminal illness who are not on life support, just as it does in prohibiting such assisted suicide generally. Conceptualizing clearly the category of persons who are in the "final stages of a terminal illness but not receiving life-sustaining treatment" is inherently problematic. That category would seem to encompass persons who *are* sick enough to be thought of as "terminally ill"—a term almost impossible to define in itself[25]—but *not* sick enough to require life-sustaining treatment. Curiously, none of the named terminally ill plaintiffs in this lawsuit appear to fall into the "protected" category, for all of them were receiving life-extending treatment which they could have declined but chose to accept. *Quill v. Vacco*, 80 F.3d at 720-21.

Furthermore, since the right to refuse medical treatment applies to everyone, it is unclear why the claimed "right" to assisted suicide would or could be confined to persons who are terminally ill. Indeed, this newly crafted

[24] John Finnis, *Intention and Side-Effects*, in R.G. Frey and Christopher Morris, eds., Liability and Responsibility: Essays in Law and Morals 32 (Cambridge University Press 1991).

[25] *See* notes 26 and 27, *infra*.

"right" arguably creates a new quagmire of equal protection problems, *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal pending*, No. 95-35804 (9th Cir.), and may also violate other laws, including the Americans with Disabilities Act. *Lee v. Oregon*, 869 F. Supp. 1491 (D. Or. 1994) (preliminary injunction).

Finally, as experience has taught, there is no clear-cut definition of terminal illness,[26] and even if there were, such diagnoses are notoriously inaccurate.[27] As this Court has observed, "it is often impossible to identify a patient as terminally ill except in retrospect. . . . Even critically ill individuals may have unexpected remissions and may respond to conventional treatment." *United States v. Rutherford*, 442 U.S. 544, 556-57 (1979) (upholding federal regulations restricting use of unsafe drugs by terminally ill patients and noting the particular vulnerability of such patients to "resourceful entrepreneurs" peddling such drugs).

Even if these several difficulties could be surmounted, the Second Circuit's analysis of the rationality of New York's prohibition of assisted suicide is seriously flawed. Empirically there is no rational relationship among (a) terminal illness, (b) suicide requests, and (c) pain. Most people who request or attempt suicide are not terminally ill.[28] The vast majority of people who are terminally ill

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[26] "[S]eventeen years of experience with State Living Will statutes that have used 'terminal condition' as a prerequisite to patient directives have demonstrated that 'terminal' lacks any truly objective, operational definition. The terminal requirement is an . . . unworkable requirement." American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of January 17, 1992, *reprinted in* 8 Issues in Law & Med. 117 (Summer 1992).

[27] Joanne Lynn, *et al., Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duq. L. Rev. 311 (1996); Eric Chevlen, *The Limits of Prognostication*, 35 Duq. L. Rev. 337 (1996).

[28] "The major studies all agree in showing that the fraction of suicide victims struggling with a terminal illness at the time of their death is in the range of 2% to 4%." David Clark, "*Rational*" *Suicide and People with Terminal Conditions or Disabilities*, 8 Issues in Law & Med. 151 (Fall 1992). Two major studies suggest that more people commit suicide under the *mistaken* belief that they have cancer than commit suicide and really have cancer. *Id.* at 159.

do not request or attempt suicide for any reason.[29] In the vast majority of cases, people who request suicide—terminally ill or not—do so for reasons other than pain.[30]

Thus, there is no reasonable correlation among these three categories of terminal illness, pain, and suicide requests. Even if there were, suicide would *not* be a rational answer to the problem of pain. The reasonable response to human needs or problems is to address the need or the problem, *not to destroy the person*. Suicide is neither a "solution" to a problem, nor a "benefit"; it takes away the one good—life itself—that makes all other goods possible. Death itself is not a benefit or a "right," but simply a fact of the human condition. Life, however, *is* a right. U.S. Const., amend. 14 (no state shall deprive any person of life without due process of law). It is, according to the Declaration of Independence, an inalienable right.

Moreover, for terminally ill patients who are in pain, the choice is not the specious one between death and the "continuation of agony" (80 F.3d at 370) that the Second Circuit posits.[31] The president-elect of the American

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[29] *Id.* at 160-61; *see also* Ezekiel J. Emanuel, *et al., Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 The Lancet 1805 (June 29, 1996).

[30] A 1990 study showed that in the Netherlands, the only Western nation currently to permit euthanasia, pain was the only reason for requesting euthanasia in only 10 of 187 cases, and a contributing factor in less than half of the cases. P.J. van der Maas, *et al., Euthanasia and Other Medical Decisions Concerning the End of Life* 44 (Elsevier Science Publishing 1992).

[31] The same unfounded and uninformed negative assumptions about persons who are terminally ill appear throughout the Ninth Circuit's opinion in *Compassion in Dying*. Such persons, the Ninth

Academy of Hospice and Palliative Medicine emphatically writes:

> As a doctor who has been involved in hospice care for more than 14 years, I can state without equivocation that the physical sources of suffering associated with dying all can be controlled. Most often, such symptoms as pain, shortness of breath and nausea, yield to routine evaluation and straightforward interventions. Even the pain of end-stage cancer commonly can be managed with oral medications. In a small percentage of cases, pain or other bothersome symptoms do require advanced interventions. Rarely, sedation is required to effectively alleviate pain, breathlessness or terminal agitation.
>
> Symptom management is not always easy. Effective therapy may require the efforts of a physician with special interest in palliative medicine and a team of hospice-trained nurses, consultant pharmacists and others. Yet I want to state again clearly that in *all* cases the physical distress of the dying can be controlled.

Ira Byock, *Kevorkian: Right Problem, Wrong Solution*, The Washington Post, January 17, 1994, at A23 (original emphasis). Pain medication is available even in the end stages of cancer.[32] Experts agree that unmanaged pain is generally due not to the unavailability of effective pain relief, but to the failure of health care providers to learn and use available techniques. New York State Task Force on Life and the Law, *supra* at 43-44. These techniques are being more fully disseminated. *Id.* at 46-47. But such progress could be forestalled if physicians were licensed to facilitate a patient's suicide rather than ease his or her pain.

Circuit supposed, face a "painful, undignified and inhumane ending to their lives," 79 F.3d at 810, are "reduced at the end . . . to a childlike state of helplessness, diapered, sedated, incontinent," *id.* at 814, and "can only be maintained in a debilitated and deteriorating state." *Id.* at 821. It is as if the court had decided that making demands upon one's community ("a childlike state of helplessness") or losing certain bodily functions ("diapered . . . incontinent") make life unworthy of being lived.

[32] "No patient with cancer needs to live or die with unrelieved pain." Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124 (Oct. 10, 1996).

Permitting physicians to prescribe drugs so patients can take their own lives has an especially grotesque twist when contrasted with the Second Circuit's desire to relieve the dying of their "agony." Supporters of assisted suicide concede that in a large number of cases (25%) an intentional overdose of prescription medication does not result in an immediate death but only leaves the patient in *greater* agony than if suicide had not been attempted. A well-known advocate of assisted suicide has admitted that a law facilitating an overdose of such drugs could have "disastrous" consequences. D. Humphry, *Oregon's Assisted Suicide Law Gives No Sure Comfort to Dying*, New York Times, Dec. 3, 1994, at 22 (letter to the editor). Humphry relied upon a Dutch study in which over 20 out of 90 people given barbiturates by mouth "lingered as long as four days." *Id.* In "15 instances the doctor gave a lethal injection because the oral drugs were causing protracted suffering to the patient, the family, and himself." *Id.*[33] Thus, permitting physicians to prescribe lethal drugs for their patients may only create suffering, not relieve it, and lead physicians to take an even more active role in causing the deaths of their patients. *See also* American Association of Suicidology, *Report of the Committee on Physician-Assisted Suicide and Euthanasia*, 26 Suicide & Life-Threatening Behavior 15 (1996 Supp.) (patients attempting physician-assisted suicide by oral medication can choke to death on their own vomitus,

[33] Twenty-five percent of those who try to kill themselves with an oral overdose prescribed by a physician are "likely to experience a lingering death that could go on for hours, maybe days." M. O'Keefe, *Dutch Researcher Warns of Lingering Deaths*, The Oregonian, Dec. 4, 1994, at A1. Dutch physician and euthanasia practitioner Pieter Admiraal says that witnessing such a death presents an "agonizing dilemma" for relatives, who will be "tempted to suffocate loved ones by putting plastic bags over their heads" when the drugs do not work quickly enough. *Id.*

"experience terror, panic, or become assaultive" as a result of intoxication from the ingested drugs, or change their mind altogether and "beg for rescue").

Finally, there is no basis for the Second Circuit's claim (80 F.3d at 729-30) that New York has a "greatly reduced" interest in protecting the lives of sick people when the state prohibitions in question are against intentional acts of killing. Judicial decisions that speak of the state's interest in preserving life as being "reduced" or "weakened," including *Quinlan*, concerned disputes about the extent to which the state could insist on affirmative efforts to prolong life despite a patient's wish to be free of unwanted medical treatment and physical intrusions. It was in *that* context that *some* courts considered the state's interest in actively prolonging life to be less serious *when weighed against the patient's wishes to be free of unwanted treatment. See, e.g., Matter of Quinlan,* 355 A.2d at 664 ("We think that the State's interest . . . weakens and the individual's right to privacy grows *as the degree of bodily invasion increases* and the prognosis dims") (emphasis added). In fact, even in the withdrawal of treatment context, this Court has completely rejected the notion that the state must have a "reduced interest" in protecting a person's life, or that this interest fluctuates with the patient's health. The state may assert "an *unqualified* interest in the preservation of human life"—that is, an interest that does not vary with the person's health condition or "quality of life." *Cruzan*, 497 U.S. at 282 (emphasis added). If, as this Court declared in *Cruzan*, the interest in protecting life is *unqualified*, then it cannot at the same time be "greatly reduced" even when the patient's medical condition is as debilitated as Nancy Cruzan's.

Moreover, any notion that the state has *less* interest in protecting a person's life against a lethal intervention when that person is very sick would itself do violence to the principle of equal justice under the law. It would mean that the law has a greater interest in protecting those who are "fit" and "healthy" than those who are sick and dependent. This is simply another way of saying that

(a) the state may decide in the first place whose life warrants greater or lesser protection (a dangerous proposition by any standard), and (b) as a matter of constitutional law, sick people, in particular, have lives less worth protecting than others. Such a governmental determination would be a direct assault on the fundamental equality and dignity of each and every person. Excluding people from the protection of the criminal law based on the condition of their health is an abdication of the Court's responsibility to ensure equal justice for all.[34] To graft such a result into the *Constitution* is simply unthinkable.

The New York State Task Force, *supra*, expressed grave reservations about the impact legalization of assisted suicide would have on those who lie on the fringes of society. The Task Force concluded that the poor and socially marginalized would most likely be pressured to resort to physician-assisted suicide if such conduct were legalized. These are precisely the people whom the Constitution was intended to protect from majoritarian impulses. Others have noted the disproportionate impact that legalization of assisted suicide would have on women.[35]

> In the United States more elderly women than elderly men are poor, widowed, live alone, suffer from chronic illness, and have limited access to medical insurance and family care. They would appear to be at great risk either to be pressured, or to feel pressured, into

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[34] The poor condition of a person's health does not remove criminal liability for his or her homicide. "The lives of all are equally under the protection of the law . . . to their last moment." *Cruzan*, 497 U.S. at 296 (Scalia, J., concurring), *quoting Blackburn v. State*, 23 Ohio St. 146, 163 (1873). In fact, under the federal sentencing guidelines, crimes against the sick and vulnerable warrant an *enhanced* sentence. United States Sentencing Commission, Guidelines Manual, Pt. A, ch. 3, § 3A1.1.

[35] Sidney Callahan, *A Feminist Case Against Self-Determined Dying in Assisted Suicide and Euthanasia*, 1 Studies in Pro Life Feminism 303-317 (Fall 1995); Nancy J. Osgood & Susan A. Eisenhandler, *Gender and Assisted and Acquiescent Suicide: A Suicidologist's Perspective*, 9 Issues in Law & Med. 361 (Spring 1994).

suicide or euthanasia to relieve others of the financial and emotional burden of caring for them.

American Association of Suicidology, 26 Suicide & Life-Threatening Behavior at 9.[36]

Thus, far from bringing about equal justice under the law, the Second Circuit's decision creates a fundamental inequity in which citizens who are most socially and economically marginalized will be least protected from their own and others' deadly intentions. Our Constitution does not require such a tragic result.

CONCLUSION

For the foregoing reasons, the judgment of the Second Circuit should be reversed.

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[36] Most of Jack Kevorkian's victims, for example, have been women. Suicide & Life Threatening Behavior, at 8-9. Because most physicians are men, and because men tend to have a more favorable view of suicide than women, there is a real danger that physicians will be "likely to take at face value a woman's request for assistance in death. . . ." *Id.* at 9.

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NO. 95-1858

THE SUPREME COURT OF THE UNITED STATES

October Term, 1996

Dennis C. Vacco, Attorney General of
the State of New York, et al., Petitioners,
v.
Timothy E. Quill, MD, et al., Respondents,

On Writ of Certiorari to the United States
Court of Appeals for the Second Circuit

NO. 96-110

THE SUPREME COURT OF THE UNITED STATES

October Term, 1996

Washington, et al., Petitioners,
v.
Harold Glucksberg, MD, et al., Respondents,

On Writ of Certiorari to the United States
Court of Appeals for the Ninth Circuit

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32 pp

TABLE OF CONTENTS

	Page
TABLE OF CONTENTS	i
TABLE OF AUTHORITIES	ii
INTEREST OF AMICUS CURIAE	1
JURISDICTIONAL STATEMENT	2
STATEMENT OF FACTS	2
POINTS RELIED ON	2
PRELIMINARY STATEMENT	4
SUMMARY	5
I. THERE IS PUBLIC AND PROFESSIONAL CONFUSION ABOUT END-OF-LIFE LEGAL AND MEDICAL ISSUES	5
II. PAIN AND OTHER PHYSICAL SYMPTOMS ASSOCIATED WITH TERMINAL ILLNESS ARE NOT ADEQUATELY MANAGED	14
III. THE NATIONAL CONTROVERSY EXISTING ABOUT PHYSICIAN-ASSISTED SUICIDE IS RELATED TO SERIOUS GAPS IN EMPIRICAL DATA	21
IV. CONCLUSION	23

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Page

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INTEREST OF AMICUS CURIAE

Choice In Dying, Inc., ("Choice In Dying") as amicus curiae, takes no position with respect to the holdings in the two cases under review by this Court, nor does it take a position with respect to the legality or constitutionality of physician-assisted suicide. Numerous briefs exploring the constitutional and legal aspects of these cases have been filed with the Court. Choice In Dying does not wish to duplicate the work done by other amici. However, to establish an empirically based framework by which these important issues may be considered, Choice In Dying deems it crucial that the Court also be fully informed about:

(1) the limitations of available empirical evidence concerning physician-assisted suicide;

(2) the important distinction between physician-assisted suicide and other accepted options for end-of-life medical care;

(3) the gap between available technology for managing pain and other symptoms associated with terminal illness and actual physician practices; and

(4) the gap between the availability of effective care for the terminally ill and its accessibility to the general public.

Choice In Dying is in a unique position to provide the Court with this information. It is the oldest and the only national organization devoted solely to a broad range of end-of-life issues. Its mission is to secure the right of patients to make decisions about their end-of-life medical care and to promote quality care of dying patients. The organization's work includes providing a professionally staffed national hotline to re-

spond to the three-to-five thousand people contacting it each month with requests for facts, counseling, consultation and crisis resolution. Choice In Dying also provides public, physician and other professional education, and monitors changes in state and federal legislation related to all end-of-life issues.

Choice In Dying respectfully submits this brief to provide the Court with a synthesis and analysis of empirical evidence available as a result of scholarly study and the organization's unique access to the actual experience of thousands of dying individuals and their surrogates.

JURISDICTIONAL STATEMENT

Amicus curiae takes no position as to any jurisdictional statements contained in the petitioners' or the respondents' briefs.

STATEMENT OF FACTS

Amicus curiae takes no position as to any statements of fact contained in the petitioners' or the respondents' briefs.

POINTS RELIED ON

I.
THERE IS PUBLIC AND PROFESSIONAL CONFUSION ABOUT END-OF-LIFE LEGAL AND MEDICAL ISSUES

A. THERE IS MISINFORMATION AND MISUNDERSTANDING ABOUT LIFE-SUSTAINING TREATMENTS

B. THERE ARE IMPORTANT DISTINCTIONS BETWEEN THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT AND PHYSICIAN-ASSISTED SUICIDE

C. IN BOTH CASES UNDER REVIEW, THE SECOND AND NINTH CIRCUIT COURTS HAVE BLURRED THE DISTINCTION BETWEEN PHYSICIAN-ASSISTED SUICIDE AND THE POTENTIAL DOUBLE EFFECT OF PAIN MEDICATION IN CERTAIN CIRCUMSTANCES

D. THERE IS A LACK OF CONSENSUS AS TO THE DEFINITIONS OF TERMINAL ILLNESS

E. INDIVIDUALS' RIGHT TO FORGO TREATMENT IS POORLY UNDERSTOOD BY THE PUBLIC AND INSUFFICIENTLY HONORED BY PROVIDERS

II.
PAIN AND OTHER PHYSICAL SYMPTOMS ASSOCIATED WITH TERMINAL ILLNESS ARE OFTEN NOT ADEQUATELY MANAGED

A. THERE IS OVERUSE OF POTENTIALLY PAINFUL LIFE-SUSTAINING TREATMENT IN DYING PATIENTS

B. DATA SUGGEST THAT DYING WITHOUT LIFE SUPPORT CAN BE A PEACEFUL PROCESS

C. TECHNOLOGY IS AVAILABLE FOR MANAGING PAIN AND OTHER SYMPTOMS ASSOCIATED WITH TERMINAL ILLNESS

D. STATE-OF-THE ART CARE FOR SYMPTOMS ASSOCIATED WITH TERMINAL ILLNESS IS NOT ROUTINELY PROVIDED

E. PUBLIC MISCONCEPTIONS ABOUT MANAGEMENT OF PAIN AND SUFFERING DISTORT DEBATE ABOUT PHYSICIAN-ASSISTED SUICIDE

III.

THE NATIONAL CONTROVERSY CONCERNING PHYSICIAN-ASSISTED SUICIDE IS RELATED TO SERIOUS GAPS IN EMPIRICAL DATA

A. EMPIRICAL DATA ABOUT PHYSICIAN ATTITUDES AND PRACTICES CONCERNING PHYSICIAN-ASSISTED SUICIDE IS LIMITED

B. EMPIRICAL DATA ABOUT PATIENT ATTITUDES AND PRACTICES CONCERNING PHYSICIAN-ASSISTED SUICIDE IS LIMITED

PRELIMINARY STATEMENT

Multiple factors contribute to the current controversy about medical care at the end of life. Among the most significant of these factors is the misapplication of medical technology for dying patients and the potential limitations in access to appropriate care at the end of life. Other factors include developing reform in the way that health care is organized and delivered,[1] evolution in the laws governing health care[2] and changes in the

[1]Ezekiel J. Emanuel, Cost Savings at the End of Life, 275 JAMA 1907, 1912 (1996).

[2]See Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990); See also Patient Self-Determination Act, 42 U.S.C. §1395 cc(f) (1)-(3) (1990) (the Act provides that health care facilities that receive Medicaid or Medicare funds must provide written information at the time of admission about patients' rights under state law to make decisions about medical care, including the right to accept or reject medical treatment and to create advance directives); Colo. Rev. Stat. §§ 15-18-101 to 15-18-113 (1987 & Supp. 1996) (which provides for proxy decision-makers for medical treatment; N.Y. Pub. Health Law §§ 2980 to 2994 (McKinney 1994 & Supp. 1996) (which provides for health care agents and proxies).

nation's demographics, including the aging of the population[3] and ethnic and cultural shifts.

Current medical technology can prevent or cure many diseases and significantly improve the quality of life for those suffering from chronic disorders. However, the same technology is often used to distort and prolong the dying process. Problems raised by the misapplication of technology and its lack of accessibility are compounded by widespread public and professional confusion or ignorance about the provision of such care.

In addition, significant gaps exist in the available empirical evidence concerning physician-assisted suicide, and public debate is at a comparatively formative stage. Reasonable consensus on these complex issues is unlikely until knowledge is more complete and widespread. As with any emerging body of thought and practice, there is inherent instability which augurs both progress and risk.

Thus, it is vitally important to differentiate among knowledge about physician-assisted suicide and medical technology that is fact-based, the fundamental questions remaining unanswered and the implication of such uncertainties.

SUMMARY OF ARGUMENT

I.

THERE IS PUBLIC AND PROFESSIONAL CONFUSION ABOUT END-OF-LIFE LEGAL AND MEDICAL ISSUES

A. THERE IS MISINFORMATION AND MISUNDERSTANDING ABOUT LIFE-SUSTAINING TREATMENTS

[3]Lakshmipathi Chelluri et al., Intensive Care for Critically Ill Elderly: Mortality, Costs, and Quality of Life, 155 Archives Internal Med. 1013, 1013 (1995).

Patients frequently misunderstand the benefits and burdens of cardiopulmonary resuscitation, which has an extremely poor outcome in dying patients.[4] Research has demonstrated that when this is clarified, patients are far less likely to choose this life-sustaining intervention.[5]

Artificial nutrition and hydration are medical treatments that can be refused like any other treatments.[6] However, there is substantial misinformation and misunderstanding regarding these particular life-sustaining treatments.[7]

Both the Ninth Circuit in Compassion in Dying v. Washington,[8] ("Compassion"), and the Second Circuit in Quill v. Vacco,[8] ("Quill"), imply in their respective opinions that artificial nutrition and hydration are qualitatively different from other forms of life-sustaining treatment. Indeed, both courts use language about refusal of artificial nutrition that is often misconstrued, including the term "starvation."[9] In addition to being medically inaccurate, the term "starvation" is often emotion-laden and raises frightening images of hungry, otherwise healthy people who are prevented from obtaining desired

[4]Leslie J. Blackhall, Must We Always Use CPR?, 317 New Eng. J. Med. 1281, 1282-1283 (1987).

[5]Donald J. Murphy, et al., The Influence of the Probability of Survival on Patients' Preferences Regarding Cardiopulmonary Resuscitation, 330 New Eng. J. Med. 545, 546-547 (1994).

[6]Cruzan v. Director, Missouri Department of Health, 497 U.S. 261, 278 (1990).

[7]Judith C. Ahronheim, Artificial Nutrition and Hydration in the Terminally Ill, 12 Clinics Geriatric Med. 379, 379-385, 387 (1996).

[8]Compassion In Dying v. Washington, 79 F.3d 790 (9th Cir. 1996), *cert. granted*, Washington v. Glucksberg, 65 U.S.L.W. 3254 (518 U.S. 1996) (no. 96-110); Quill v. Vacco, 80 F.3d 716 (2nd Cir. 1996), *cert. granted*, Vacco v. Quill, 65 U.S.L.W. 3254 (518 U.S. 1996) (No. 95-1858).

[9]Compassion, 79 F.3d at 822 (the court notes that states permit patients to discontinue artificial nutrition and hydration, "thus permitting the patients to die by self-starvation." The court also referred to Cruzan, where the removal of the feeding and hydration tube would allow her to "starve to death"); Quill, 80 F.3d at 729 (the court indicated that "the withdrawal of nutrition brings on death by starvation" and "the withdrawal of hydration brings on death by dehydration").

food.[10] The opinions further refer to forgoing artificial nutrition and hydration as "death by starvation," and "death by dehydration."[11] At the same time, the opinions fail to indicate that the nutritional deficiencies of starvation are insufficient to cause death early on.[12]

Artificial nutrition and hydration are medical treatments and should not be distinguished from other forms of life-sustaining treatment. The imposition of artificial nutrition and hydration may actually contribute to an uncomfortable death.[13] There is no evidence that individuals who are dependent upon artificial nutrition and hydration, whether alert and aware or with partial or severe neurological impairments, would experience any discomfort if these treatments were forgone. Indeed, extensive indirect evidence indicates that forgoing artificial nutrition and hydration facilitates natural death without discomfort.[14]

[10]Judith C. Ahronheim & M. Rose Gasner, The Sloganism of Starvation, 1 Lancet 278, 278 (1990).

[11]In Compassion, 79 F.3d at 822 (the court notes that states permit patients to discontinue artificial nutrition and hydration, "thus permitting the patients to die by self-starvation." The court also refers to Cruzan, where the removal of the feeding and hydration tube would allow her to "starve to death"); Quill, 80 F.3d at 729 (the court indicats that "the withdrawal of nutrition brings on death by starvation" and "the withdrawal of hydration brings on death by dehydration").

[12]Judith C. Ahronheim & M. Rose Gasner, The Sloganism of Starvation, 1 Lancet 278, 279 (1990).

[13]Judith C. Ahronheim, Artificial Nutrition and Hydration in the Terminally Ill, 12 Clinics Geriatric Med. 379, 380-381 (1996). (For example, enteral tube feeding [artificial nutrition and hydration via a tube placed into the stomach or small intestine] may produce a variety of uncomfortable symptoms and discontinuance may alleviate the discomfort.)

[14]Id. at 385.

Specifically, direct evidence indicates that competent hospice patients eat and drink little at the end of their lives and do not experience additional discomfort by avoiding artificial nutrition and hydration.[15]

The majority of case calls[16] regarding unwanted treatment received by Choice In Dying involve artificial nutrition and hydration.[17] These calls range from complex points of clarification to conflict resolution. This direct experience further highlights the misconceptions and continuing controversy surrounding this treatment.

Thus, despite the established constitutional right of the individual to forgo life-sustaining treatments, including artificial nutrition and hydration, ignorance of the law and misunderstanding about the treatments themselves indicates a far-reaching societal concern.

B. THERE ARE IMPORTANT DISTINCTIONS BETWEEN THE WITHHOLDING OR WITHDRAWAL OF LIFE-SUSTAINING TREATMENT AND PHYSICIAN-ASSISTED SUICIDE

The Second Circuit in Quill, supra, and the Ninth Circuit in Compassion, supra, confused the distinctions between physi-

[15]Robert M. McCann, et al., Comfort Care for Terminally Ill Patients: The Appropriate Use of Nutrition and Hydration, 272 JAMA 1263, 1264-1265 (1994).

[16]Choice In Dying provides a national hotline to respond to individual requests for counseling, consultation and crisis resolution ("case calls").

[17]66% of 600 calls received between January 1994 and July 1996.

[18]Quill, 80 F.3d at 727 (where the court held that those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated); Quill, 80 F.3d at 729 (where the court held that by withholding or withdrawing a patient "hastens his death by means that are not natural in any sense.")

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cian-assisted suicide and the forgoing of life-sustaining treatment.

In Quill, the court repeatedly refers to termination of life support as the "hastening of death."[18] In Compassion, the court looks to the Cruzan case as a recognition that the termination of life-support is the hastening of death.[19]

The forgoing of life-sustaining treatment refers to the avoidance of a medical treatment that is necessary to sustain life. These treatments include cardiopulmonary resuscitation when heartbeat or breathing stops; mechanical ventilation when the patient can no longer breathe without artificial support; artificial nutrition and hydration when a person cannot eat or drink enough by mouth to sustain life; or a procedure to take the place of a malfunctioning vital organ, such as dialysis for failed
kidneys.[20]

These life-sustaining treatments artificially postpone natural death, and the withholding or withdrawing of these treatments removes the obstacle. The Ninth Circuit, when discussing Cruzan, noted that Nancy Cruzan lived with artificial nutrition and hydration for 8 years. A person in a persistent vegetative state[22] ("PVS") cannot live without artificial nutrition and hydration. The existence of individuals in PVS continues far beyond the time they would have died a natural death

[19]Compassion, 799 F.3d at 816 (the court viewed Cruzan as a case that hastened death: "...Cruzan, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, necessarily recognizes a liberty interest in hastening one's own death.").

[20]When these treatments prolong life in someone with serious underlying illness, such as cancer or Alzheimer's disease, they will enable the patient to survive into a more advanced and debilitating stage of the disease.

[21]Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990).

[22]The Multi-Society Task Force on PVS, Am. Acad. of Neurology, No. 21, Pt. 1, Medical Aspects of the Persistent Vegetative State, 330 New Eng. J. Med. 1499-1502 (1994).

because of the artificial prolongation of life.

By contrast to the above, physician-assisted suicide is a specific intervention that actively hastens death. A failure to comply with a request to withhold or withdraw life-sustaining treat- ment would subject an individual to unwanted treatment and, as such, make him or her a virtual''prisoner of medical technology."[23] A failure to comply with a request for physician-assisted suicide would restrict patient autonomy, but would not amount to a bodily invasion.[24]

C. IN BOTH CASES UNDER REVIEW, THE SECOND AND NINTH CIRCUIT COURTS HAVE BLURRED THE DISTINCTION BETWEEN PHYSICIAN-ASSISTED SUICIDE AND THE POTENTIAL DOUBLE EFFECT OF PAIN MEDICATION IN CERTAIN CIRCUMSTANCES

The term "double effect" refers to the administration of pain medication with the intention of providing relief from suffering, with the possible secondary effect of hastening death. However, such hastening of death is theoretical.[25]

In the two cases under review, both courts have confused the distinction between physician-assisted suicide and double effect,[26] treating them as though they are equivalent. These

[23]Franklin G. Miller, Legalizing Physician-Assisted Suicide by Judicial Decision: A Critical Appraisal, 1, 10 (April 1996) (unpublished manuscript).

[24]Id. at 10.

[25]Compassion, 79 F.3d at 823 (the court, in discussing double effect, notes that the medication "will" cause death, although citing language from physicians that it "may" cause death).

[26]Compassion, 79 F.3d at 824 (the court notes that there was little or no difference "for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life).

[27]David A. Asch, The Role of Critical Care Nurses in Euthanasia and

concepts also have been blurred by professionals, as witnessed in a recent study of intensive care nurses, some of whom considered administration of symptom-controlling medication to be the same as euthanasia.[27]

Among ethicists and within the law there is widespread consensus that the "double effect" is a morally acceptable risk in the context of the great suffering of the terminally ill.[28] By contrast, there is persistent controversy over the provision of medications in order to deliberately hasten death, as in physician-assisted suicide, regardless of the extent of the patient's suffering.[29]

The medications administered to relieve suffering may also lower blood pressure and depress respiration, and become "risky" in patients with low blood pressure or respiratory failure. However, it is not possible to prove whether the disease or the medication is responsible for the precise moment of death. A patient undergoing terminal respirator withdrawal, also known as "terminal weaning," is likely to have intense fear, anxiety and breathlessness unless precautions are taken, such as adjustment of the respirator settings or administration of sufficient sedation, for example, with morphine. Either method increases carbon dioxide levels in the blood, and produces respiratory failure. However, since withdrawal of the respirator with or without palliation will inevitably result in death, it is not possible to know if the morphine or the disease produced the actual moment of death.[30]

In contrast to the theoretical hastening of death in someone with low blood pressure or respiratory failure, the effect of a

Assisted Suicide, 334 New Eng. J. Med. 1374, 1376 (1996).

[28]The New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context, 1, 163 (1994).

[29]Id. at 162.

[30]William C. Wilson, et al., Ordering and Administration of Sedatives and Analgesics During the Withholding and Withdrawal of Life Support

lethal dose of medication (either a known lethal dose in someone who has not developed tolerance to that medication, or an extremely large incremental dose in someone who already has been taking the medication) is predictable when it is given to someone who is not physiologically near death.

D. THERE IS A LACK OF CONSENSUS AS TO THE DEFINITIONS OF TERMINAL ILLNESS

In Quill, supra, the court indicated that physicians would agree on when the "final stages" of a "terminal illness" would occur,[31] and in Compassion, supra, the court stated that "[W]hile defining the term 'terminally ill' is not free from difficulty, the experience of the states has proved that the class of the terminally ill is neither indefinable nor undefined..."[32] Notwithstanding these opinions, Choice In Dying has often found profound disagreement among professionals and others concerning the definition of terminal illness.

Terminal illness has been variously defined by the states. New York has defined the term by applying a time of of one year.[33] New Jersey defines terminal condition as requiring a life expectancy of six months or less, with or without the provision of life-sustaining treatment."[34] Colorado defines terminal condition as one in which the administration of life-sustaining procedures will serve only to postpone the moment of death.[35]

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from Critically Ill Patients. 267 JAMA 949, 951-953 (1992).

[31]Quill , 80 F.3d at 731.

[32]Compassion, 79 F.3d at 831.

[33]N.Y. Pub. Health Law §2961(23) (McKinney 1996).

[34]N.J. Stat. Ann. §26:2H-55 (West 1995).

[35]Colo. Rev. Stat. §15-18-103(10) (1996).

[36]Cal. Health & Safety Code §7186(j) (West 1996).

[37]Ill. Comp. Stat. 110 1/2, §702(h) (West 1995).

[38]Mo. Ann. Stat. §459.010(6) (1992).

California defines terminal condition as a condition that results in death within a relatively short time without the administration of life-sustaining treatment[36] and Illinois as one in which death is imminent.[37] Lastly, Missouri requires that death will occur within a short time regardless of the application of medical procedures.[38]

Furthermore, it recently has been reported[39] that 14.9% of patients referred to hospice actually lived longer than 6 months, which is the maximum projected life expectancy that satisfies the hospice definition of "terminal illness." Additional studies have documented the uncertainties involved in predicting survival among patients with a variety of serious illnesses.[40]

The variety of existing definitions of "terminal illness" and the inability to accurately predict the time of death illustrates confusion, not clarity, regarding what constitutes terminal illness.

E. INDIVIDUALS' RIGHT TO FORGO TREATMENT IS POORLY UNDERSTOOD BY THE PUBLIC AND INSUFFICIENTLY HONORED BY PROVIDERS

Choice In Dying's experince over time illustrates that patients frequently receive unwanted medical treatments that prolong their lives, and conflict often continues to occur between

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[39]Nicholas A. Christakis & Jose J. Escarce, Survival of Medicare Patients After Enrollment in Hospice Programs, 335 New Eng. J. Med. 172, 174 (1996).

[40]David B. Reuben et al., Clinical Symptoms and Length of Survival in Patients with Terminal Cancer, 148 Archives Internal Med. 1586, 1588 (1988); Robert A. Pearlman, Variability in Physician Estimates of Survival in Acute Respiratory Failure in Chronic Obstructive Pulmonary Disease, 91 Chest 515, 516-517 (1987).

providers and patients.

Among 922 case calls received during a recent 30-month period, 65% involved concerns over unwanted treatments, and in 74% of these instances there was a dispute, usually between a patient or family member and the health care provider over the use of life-sustaining treatments.

In approximately 75% of case calls, the caller states that the patient in question has executed a formal advance directive. This rate is much higher than among the public at large (15%-25%) and even higher than selected groups with terminal illness (more than 50%).[41] Because patients with advance directives tend to be better educated and more affluent,[42] the problem of unwanted treatment may well be much broader demographically than is suggested by Choice In Dying's experience.

Furthermore, earlier published experience from Choice in Dying regarding conflicts over artificial nutrition and hydration illustrated that patients represented by case calls were much older and reflected a broader range of clinical situations than those represented by case law on which legal theory has been based.[43]

This organization's actual experience and the most recent studies on physician-patient communication and physician biases highlight the need for the courts to be thoroughly apprised of patient-based attitudes and experiences.

II.
PAIN AND OTHER PHYSICAL SYMPTOMS

[41]Steven H. Miles, et al., Advance End-of-Life Treatment Planning, 156 Archives Internal Med. 1062, 1063 (1996).

[42]Id. at 1063.

[43]Judith C. Ahronheim & Michael Mulvihill, Refusal of Tube Feeding as Seen From a Patient Advocacy Organization: A Comparison With Landmark Cases, 39 J. Am. Geriatric Soc'y 1124, 1125-6 (1991).

ASSOCIATED WITH TERMINAL ILLNESS ARE OFTEN NOT ADEQUATELY MANAGED

A. THERE IS OVERUSE OF POTENTIALLY PAINFUL LIFE-SUSTAINING TREATMENT IN DYING PATIENTS

Many terminally ill patients are overtreated with invasive and sometimes painful procedures and treatments that prolong their lives.

According to a recent multicenter study, death often is preceded by protracted hospital stays involving invasive treatments, with possibly 50% of patients dying in pain.[44] In one series of incurably ill hospitalized patients, one or more invasive nonpalliative treatments was instituted in 47% of the cases.[45]

Overtreatment of terminally ill patients with invasive and sometimes painful procedures may be, in part, the result of poor attention by physicians to patient preferences about certain end-of-life treatment decisions.[46] Physician biases are implicated as well, including a preference for withdrawing certain life-sustaining treatments over others, despite similar clinical circumstances.[47]

Poor communication between physicians and patients and physician's biases may have significant ramifications for pa-

[44]The SUPPORT Principal Investigators, A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT), 274 JAMA 1591, 1594 (1995).

[45]Judith C. Ahronheim et al., Treatment of the Dying in the Acute-Care Hospital: Advanced Dementia and Metastatic Cancer, 56 Archives Internal Med. 2094, 2096 (1996).

[46]The SUPPORT Principal Investigators, at 1591, 1595.

[47]Nicholas A. Christakis & David A. Asch, Biases in How Physicians Choose to Withdraw Life Support, 342 Lancet 642, 643 (1993).

[48]Ivan Lichter & Esther Hunt, The Last 48 Hours of Life, 6 J. Palliative

tients in terms of personal autonomy and ultimately for appropriate palliative care. It is imperative that the court understand these dynamics as they bear upon the issue of physician-assisted suicide.

B. DATA SUGGEST THAT DYING WITHOUT LIFE SUPPORT CAN BE A PEACEFUL PROCESS

Severe discomfort is not invariably associated with the final stages of a terminal illness.[48]

Many people remain alert or semi-alert until the end, but many develop coma[49] prior to death. Coma has many causes but can stem from potentially reversible medical illness.[50] The treatment and reversal of medically induced coma can restore alertness without improving the prognosis of the underlying illness.

In dying patients, coma may act as a natural form of anesthesia so that the hours or days before death are devoid of pain, fear or suffering.[51] This disease-induced ("natural") condition resembles a drug-induced sleep similar to anesthesia. Avoiding treatment that would revers coma allows death to occur naturally and peacefully.

C. TECHNOLOGY IS AVAILABLE FOR MANAGING

Care 7 (1990).

[49]Fred Plum & Jerome B. Posner, The Diagnosis of Stupor and Coma, No. 19, at 5 (Fred Plum & Fletcher H. McDowell, eds., 3rd ed., 1980). (Coma is an unarousable sleep-like state in which a person demonstrates no ability to experience pleasure, pain or suffering.)

[50]Id. at 177-180.

[51]Judith Ahronheim & Doron Weber, Final Passages: Positive Choices For the Dying and TheirLoved Ones, 160-179 (Fred Hills, ed., Simon & Schuster 1992).

[52]Detlev FJ Zech, et al., Validation of World Health Organization Guidelines for Cancer Pain Relief: A 10-year Prospective Study, 63 Pain 65, 73 (1995).

PAIN AND OTHER SYMPTOMS ASSOCIATED WITH TERMINAL ILLNESS

Pain and other physical symptoms can be appropriately controlled, in the vast majority of cases, within the confines of standard medical practice.

In approximately 90% of cancer patients, pain can be adequately controlled when standard, accepted measures are used.[52] Although potent medications sometimes can reduce alertness, psychostimulant medications are available that can ameliorate that problem.[53] Furthermore, a variety of management techniques are available that can ameliorate other physical symptoms associated with terminal illness, such as vomiting and breathing difficulties.[54] These approaches, along with a large and evolving body of knowledge, are embodied in the discipline of "palliative medicine."[55]

Despite the advances that have been made in symptom control, physical symptoms remain uncontrolled in some individu-

[53]Nathan I. Cherney & Kathleen M. Foley, Nonopioid and Opioid Analgesic Pharmacotherapy of Cancer Pain, 10 Hematology/Oncology Clinics N. Am. 79, 94 (1996).

[54]Lichter & Hunt, supra, at 8, 8-13.

[55]Oxford Textbook of Palliative Medicine, Derek Doyle, et al., (eds)., (1993).

[56]William R. Greene & William H. Davis, Titrated Intravenous Barbiturates in the Control of Symptoms in Patients with Terminal Cancer, 84 S. Med. J 332, 332-335 (1991).

[57]Susan D. Block & J. Andrew Billings, Patient Requests to Hasten Death, 154 Archives Internal Med. 2039, 2040 (1994). (Block and Billings have stated that "euthanasia and assisted suicide may... become irrelevant.").

[58]Daniel N. Levin, et al., Public Attitudes Toward Cancer Pain, 42 Cancer 1385 (1985).

[59]Kathleen M. Foley, The Relationship of Pain and Symptom Management to Patient Requests For Physician-Assisted Suicide, 6 J. Pain

als and relief will not be adequate unless these patients receive treatment that will suppress consciousness.[56] Although commentators have noted that patients are likely to feel reassured that this option is available,[57] some patients wish to remain alert, and would find suicide preferable to suppression of consciousness.

Although fear of unremitting pain is an important public concern that could increase the resort to assisted suicide in some individuals,[58] adequate control of pain and physical symptoms may lead to a decrease in requests for suicide.[59] In one series, only one half of one percent of hospice patients persistent requests to hasten death,[60] suggesting that in supportive settings, where pain is well managed, a reduction in suicide requests would occur.

A critical dichotomy exists between pain or other physical symptoms and the phenomenon termed "suffering." Suffering is a highly subjective, individual experience, which may, but does not always, evolve from pain or other physical symptoms.[61]

Moreover, psychiatric illness or other psychosocial factors,

& Symptom Mgmt 289, 290 (1991).

[60]Block & Billings, supra, at 2040 (1994).

[61]Eric J. Cassel, The Nature of Suffering and the Goals of Medicine, (1991).

[62]Ezekiel J. Emanuel, Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public, 347 Lancet 1805, 1809 (1996); Harvey Max Chochinov et al., Desire for Death in the Terminally Ill, 152 Am. J. Psychiatry 1185, 1188 (1995); William Breitbart et al., Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients, 153 Am. J. Psychiatry 238, 240 (1996).

[63]William Breitbart, Psychiatric Management of Cancer Pain, 63 Cancer 2336, 2337 (1989).

[64]Id. at 2337.

[65]William Breitbart et al., Psychiatric Aspects of Palliative Care, Oxford Textbook of Palliative Med. 613 (Derek Doyle et al. eds., 1993).

even more than intolerable physical symptoms, may increase interest in physician-assisted suicide, or may increase the desire to die among the terminally ill.[62] Psychiatric illness may also be the primary cause of unremitting suffering.

Psychiatric disorders, especially depression, increase the risk of suicide among the terminally ill.[63] In addition, disease or drug-induced delirium also may increase the risk.[64] Although the desire for death in terminally ill patients is closely associated with clinical depression, even depression associated with dying can be treated adequately.[65]

Finally, discussion regarding unremitting pain and symptoms must include those individuals with chronic illnesses who are not "terminally ill," including patients with diseases such as multiple sclerosis, stroke, Alzheimer's disease or severe autoimmune disease. Any ruling on the narrow question before this Court may not necessarily address the intractable and intolerable suffering of those who do not have a medical illness or whose condition has not been defined as "terminal."

D. STATE-OF-THE ART CARE FOR SYMPTOMS ASSOCIATED WITH TERMINAL ILLNESS IS NOT ROUTINELY PROVIDED

Studies have indicated that pain is undertreated in people with serious illnesses,[66] despite the availability of appropriate treatments. Although the means exist to address and alleviate psychiatric illness in incurable disease, little empirical evi-

[66]William Breitbart et al., The Undertreatment of Pain in Ambulatory AIDS Patients, 65 Pain 243, 247 (1996); Charles S. Cleeland et al., Pain and Its Treatment in Outpatients with Metastatic Cancer, 330 New Eng. J. Med. 592, 593-594 (1994).

[67]Jamie H. Von Roenn et al., Physician Attitudes and Practice in Cancer Pain Management: A Survey From the Eastern Cooperative Oncology Group, 119 Annals Internal Med. 121 (1993); Kathleen M. Foley, The Relationship of Pain and Symptom Management to Patient Requests For

dence exists about the extent to which management of these symptoms is practiced.

There are remediable reasons for the undertreatment of pain and suffering associated with terminal illness, including, but not limited to, a lack of third-party insurance coverage, a lack of professional education, unwarranted fears of addiction and concerns regarding legal restrictions in the use of controlled substances.[67]

Access to effective palliative care may be limited. The lack of access is due in part to the limited number of sites where this care is provided and to lack of adequate third-party insurance coverage.

Estimates are that the 2,000 certified hospices in the United States are involved in managing fewer than 15% of deaths.[68] In addition, these programs are largely home-based, requiring able-bodied caregivers in the home, a criterion not always met in today's society. Medicare does provide coverage for hospice care, but the availability of the benefit and mechanics of electing it are often poorly understood by beneficiaries. Similarly, there is lack of awareness and understanding of hospice benefits under private plans because this coverage also is a fairly new addition to many policies.

Only recently the Health Care Financing Administration began to study reimbursement of palliative or terminal care in the acute care setting.[69] Such coverage would address a critical need because approximately 60% of adult Americans currently die as inpatients in acute-care hospitals.[70]

E. PUBLIC MISCONCEPTIONS ABOUT MANAGE-

Physician-Assisted Suicide, 6 J Pain & Symptom Mgmt 289 (1991).

[68]Hospice Fact Sheet, (National Hospice Organization), July 1, 1996.

[69]Christine K. Cassel & Bruce C. Vladek, ICD-9 Code for Palliative or Terminal Care, 335 New Eng. J. Med. 1232, 1232 (1996).

MENT OF PAIN AND SUFFERING DISTORT DEBATE ABOUT PHYSICIAN-ASSISTED SUICIDE

Most individuals with terminal illness do not have to experience undue suffering. However, pain and physical symptoms are primary concerns patients have about dying, even though medical technology is available to relieve severe pain and other physical symptoms. In Compassion, supra, the court reflected the prevailing feeling that extreme pain and physical symptoms are inevitably associated with terminal illness.[71] Public education is critical to dispelling this misconception and enhanced professional education is necessary to ensure that competent pain management is among accessible end-of-life care options.

III.
THE NATIONAL CONTROVERSY CONCERNING PHYSICIAN-ASSISTED SUICIDE IS RELATED TO SERIOUS GAPS IN EMPIRICAL DATA

EMPIRICAL DATA ABOUT PHYSICIAN ATTITUDES AND PRACTICES CONCERNING PHYSICIAN-ASSISTED SUICIDE IS LIMITED

A.

The surveys concerning physicians' attitudes toward participating in hastening patients' death and their actual practices vary considerably in the specificity of the questions, the characteristics of the physicians surveyed, the response rates, the results and the methodologic quality. In

[70]National Center for Health Statistics, U.S. Dep't of Health and Hum Services, Vol. II- Mortality, Pt.A, Vital Statistics of the United States, 380, 381 (1993).

[71]Compassion, 79 F.3d at 812 ("Americans are living longer, and when they finally succumb to illness, lingering longer, either in great pain or in a stuporous, semi-comatose condition that results from the infusion of vast amounts of pain killing medications.").

terms of their generalizability to the country overall, most of the studies have inherent limitations and/or serious methodologic flaws.

In general, response rates in these surveys have increased over the years apparently since the debate has become more public and physicians less concerned about responding to questions in this area.[72]

B. EMPIRICAL DATA ABOUT PATIENT ATTITUDES AND PRACTICES CONCERNING PHYSICIAN-ASSISTED SUICIDE ARE LIMITED

Although studies indicate that the desire for death is not uncommon among terminally ill patients,[73] there has been little study of patients who actually request assistance from their physicians in hastening their death. The limited data available are based primarily on reports from physicians.[74]

Approximately 11% of Choice In Dying case calls are inquiries about assisted dying. Among 95 recent cases, fewer than half were calling on their own behalf; 59 (63%) were inquiring about assistance for others, usually family members or close friends. Among the group for whom family or close friends were seeking assistance, only 31 reportedly were able to communicate their wishes, 17 could not do so, the capacity of 9 was uncertain, and 2 had psychiatric disease rather than medical illness. Although most calls involved people with terminal illness, including cancer and AIDS, 8 had chronic medical illness, 10 had dementia, 5 had strokes, 3 had prolonged unconsciousness and 3 had other severe neurological impairments. Two calls involved impaired newborns. None of these calls involved inquiries about withholding or withdrawing life support.

Thus, Choice In Dying's experience is consistent with the notion that societal concerns about aid in dying are very broadly based. Concerns extend not only to an array of illnesses but also to patients with limited or lack of capacity.

[72]A significant amount of the data came from Washington and Oregon, where physician-assisted suicide has been the subject of public referenda.

[73]Chochinov et al., supra (44.5% of terminally ill hospice patients indicated that they had occasional desires for death.)

[74]Paul J. van der Maas et al., Euthanasia and Other Medical Decisions Concerning the End of Life, 338 Lancet 669, 670 (1991); Anthony L. Back et al., Physician-Assisted Suicide and Euthanasia in Washington state, 275 JAMA 919, 922 (1996).

IV. CONCLUSION

Choice In Dying takes no position with respect to the holdings in the two cases before the Court, nor with respect to the legality or constitutionality of physician-assisted suicide. However, when this Court decides these cases and the important constitutional issues that underlie them, we respectfully ask that it consider the data we have presented in this submission. From such data, we respectfully submit the following conclusions should be drawn:

- There is a crucial distinction between a patient's decision to forgo medical treatment at the end of life and his decision to seek the assistance of a physician in committing suicide.
- There is no public or professional consensus by which "terminal illness" may be defined, nor does the term even encompass many individuals who are not "terminally ill" who seek to forgo life-sustaining treatments, These distinctions are central to any thorough analysis of physician--assisted suicide.

Contrary to public and judicial opinion, there is effective technology available for managing pain and other symptoms associated with terminal illness. There no longer is any technologic reason for most people to die in agony.

- There is preliminary evidence that when pain and other symptoms of terminal illness are managed effectively, desire and requests for physician-assisted suicide are reduced.

- There is evidence that potentially painful life-sustaining treatments are vastly overused among dying patients, and that withdrawing these treatments properly in individuals close to death causes little or no discomfort.

- Contrary to some public and professional opinion, forgoing artificial nutrition and hydration contributes to comfort in dying patients.

- Cardiopulmonary resuscitation has negligible or no benefit in individuals close to death and frequently is refused when patients and their families are informed of the burdens and lack of benefit associated with this life-sustaining treatment.

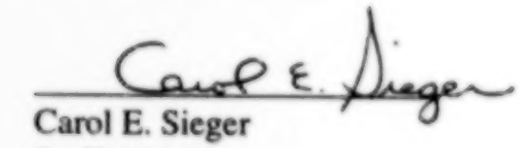
- Treating pain and other symptoms associated with terminal illness and withholding or withdrawing life sustaining treatments permits a natural death to occur. The process of natural death can be pain-free in many cases.

- Despite technologic capacity, palliative care is not widely provided and there is limited third-party coverage for such services.

- Evidence from Choice In Dying's direct contact with patients and providers indicates that many patients still receive unwanted treatment, and that unwanted treatment, as a concern, may far outweigh desire for assisted suicide among the dying.

We respectfully submit that the opinions under review do not adequately consider the factors enumerated above. Indeed, both Quill and Compassion rely significantly upon some of the serious misconceptions that we have sought to clarify in this submission. We respectfully ask the Court, in resolving the important issues at bar, to consider the data we have presented and the important conclusions drawn therefrom.

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No. 95-1858

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In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

BRIEF OF *AMICI CURIAE* STATES OF CALIFORNIA, ALABAMA, COLORADO, FLORIDA, GEORGIA, ILLINOIS, IOWA, LOUISIANA, MARYLAND, MICHIGAN, MISSISSIPPI, MONTANA, NEBRASKA, NEW HAMPSHIRE, OKLAHOMA, SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, VIRGINIA AND WASHINGTON AND THE COMMONWEALTH OF PUERTO RICO IN SUPPORT OF PETITIONERS DENNIS C. VACCO, ET AL.

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF THE *AMICI* STATES..... 1

SUMMARY OF ARGUMENT 2

ARGUMENT..... 5

I. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE DOES NOT TREAT SIMILARLY SITUATED PERSONS IN AN UNEQUAL MANNER 5

A. The Refusal of Unwanted Life-Sustaining Medical Treatment Is Not The Equivalent Of Suicide Or Assisted Suicide, And Thus, New York's Prohibition Of Assisted Suicide Does Not Create A Class of Similarly Situated Persons 7

B. The New York Authorities Relied Upon By The Second Circuit Do Not Support Its Conclusion That New York Has Recognized A Right To Commit Suicide Or "Hasten Death"..... 13

II. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS RATIONALLY RELATED TO NUMEROUS IMPORTANT GOVERNMENTAL OBJECTIVES..... 16

III. THE SECOND CIRCUIT'S CONSTITUTIONAL ANALYSIS WAS FUNDAMENTALLY FLAWED BY THE IMPROPER INSERTION OF QUALITY-OF-LIFE CONSIDERATIONS 23

IV. THE DECISION BELOW SHOULD BE REVERSED IN ORDER TO PRESERVE THE ESSENTIAL ROLE OF THE STATES IN OUR FEDERAL SYSTEM OF GOVERNMENT AND THE POWER OF THE PEOPLE TO DIRECTLY GOVERN THEIR OWN AFFAIRS 27

CONCLUSION 30

TABLE OF AUTHORITIES

Page

CASES

Allied Stores of Ohio v. Bowers, 358 U.S. 522 (1959) 17

Application of President & Directors of Georgetown College, Inc., 118 U.S.App.D.C. 80, 331 F.2d 1000 (1964), *cert. denied*, 377 U.S. 978 (1964) 21

Bartling v. Superior Court, 163 Cal.App.3d 186, 209 Cal.Rptr. 220 (1984) 8, 21

Blackburn v. State, 23 Ohio St. 146 (1872) 12, 24

Bouvia v. Superior Court, 179 Cal.App.3d 1127, 225 Cal.Rptr. 297 (1986) 8

Bowen v. Owens, 476 U.S. 340 (1986) 22

Bowers v. Hardwick, 478 U.S. 186 (1986) 25

Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985) 5, 17, 18

Clements v. Fashing, 457 U.S. 957 (1982) 17

Commonwealth v. Mink, 123 Mass. 422 (1877) 12

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996), *cert. granted*, ___ U.S. ___ (1996 WL 411596) (1996) 4, 30

Compassion in Dying v. State of Washington, 49 F.3d 586 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996) 21

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) ..... *passim*

TABLE OF AUTHORITIES – Continued

Page

Cruzan v. Harmon, 760 S.W.2d 408 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) 4, 24

Dallas v. Stanglin, 490 U.S. 19 (1989) 18, 23, 26

Dandridge v. Williams, 397 U.S. 471 (1970) 6, 18, 22, 27

DeGrella v. Elston, 858 S.W.2d 698 (Ky. 1993) 8

Donaldson v. Lungren, 2 Cal.App.4th 1614, 4 Cal.Rptr.2d 59 (1992) 8, 20, 23, 28

FCC v. Beach Communications, Inc., 508 U.S. 307 (1993) 17, 19

Garcia v. San Antonio Metro., 469 U.S. 528 (1985) 2, 28, 30

Gregory v. Ashcroft, 501 U.S. 452 (1991) 3, 22, 28

Heller v. Doe, 509 U.S. 312 (1993) 19, 21, 22, 26

In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) 8

In re Eric J., 25 Cal.3d 522, 159 Cal.Rptr. 317 (1979) 6

In re Joseph G., 34 Cal.3d 429, 194 Cal.Rptr. 163- (1983) 11

In re Quinlan, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976) 8, 9

Kadrmas v. Dickinson Public Schools, 487 U.S. 450 (1988) 17, 22

Lane County v. Oregon, 7 Wall. 71 (1869) 3

Lee v. State of Oregon, 891 F.Supp. 1421 (D.Or. 1995) 29

Lochner v. New York, 198 U.S. 45 (1905) 1, 2

TABLE OF AUTHORITIES – Continued

Page

Mack v. Mack, 618 A.2d 744 (Md. 1993) 24

Massachusetts Board of Retirement v. Murgia, 427 U.S. 307 (1976) 22

Matter of Storar, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981) 14

McGowan v. Maryland, 366 U.S. 420 (1961) 18, 22

McKay v. Bergstedt, 106 Nev. 808, 801 P.2d 617 (1990) 9

Middlesex Ethics Committee v. Garden State Bar Association, 457 U.S. 423 (1982) 20

New State Ice Co. v. Liebmann, 285 U.S. 262 (1932) 28

Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1973) 25

People v. Adams, 216 Cal.App.3d 1431, 265 Cal.Rptr. 568 (1990) 8

People v. Kevorkian, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 115 S. Ct. 1795 (1995) 2, 4, 8, 9, 11, 12, 28

Personnel Administrator of Massachusetts v. Feeney, 442 U.S. 256 (1979) 7

Planned Parenthood v. Casey, 505 U.S. 833 (1992). .24, 25

Plyer v. Doe, 457 U.S. 202 (1982) 7

Poe v. Ullman, 367 U.S. 497 (1961) 28

Quill v. Koppell, 870 F.Supp. 78 (S.D.N.Y. 1994), *aff'd in part and rev'd in part sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) 6

TABLE OF AUTHORITIES – Continued

Page

Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996), *cert. granted*, ___U.S.___ (1996 WL 282544) (1996) ..... *passim*

Rivers v. Katz, 67 N.Y.2d 485, 495 N.E.2d 337 (1986) 15

Rodriguez v. Attorney General of Canada, et al., 3 S.C.R. 519 (1993) 29

Roe v. Wade, 410 U.S. 113 (1973) 25

San Antonio School District v. Rodriguez, 411 U.S. 1 (1973) ..... *passim*

Satz v. Perlmutter, 362 So.2d 160 (Fla. DCA 1978), *aff'd*, 379 So.2d. 359 (Fla. 1980) 8

Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914) 13

State v. Jones, 86 S.C. 17, 67 S.E. 160 (1910) 12

State v. Willis, 255 N.C. 473, 121 S.E.2d 854 (1961) 12

Tafflin v. Levitt, 493 U.S. 455 (1990) 3

Texas v. White, 7 Wall. 700 (1869) 3

Thor v. Superior Court, 5 Cal.4th 725, 21 Cal.Rptr.2d 357 (1993) 8

Tigner v. Texas, 310 U.S. 141 (1940) 13

Vance v. Bradley, 440 U.S. 93 (1979) 22, 26

Von Holden v. Chapman, 87 A.D.2d 66, 450 N.Y.S.2d 623 (1982) 8

Washington v. Davis, 426 U.S. 229 (1976) 7, 22

Yick Wo v. Hopkins, 118 U.S. 356 (1886) 6

TABLE OF AUTHORITIES – Continued

Page

CONSTITUTIONAL PROVISIONS

U.S. Const. amend. X 1

U.S. Const. amend. XIV, § 1 ..... *passim*

U.S. Const. art. VI, § 2 3

STATUTES

Ala. Code

§ 22-8A-10 (1990) 9

Alaska Stat.

§ 18.12.080(f) (Michie 1994) 9

§ 11.41.120(a)(2) (Michie 1989) 11

Ariz. Rev. Stat. Ann.

§ 36-3210 (West Supp. 1995) 9

§ 13-1103(A)(3) (West Supp. 1995) 11

Ark. Code Ann.

§ 20-17-210(g) (1991) 9

§ 5-10-104(a)(2) (Michie 1993) 11

Cal. Health & Safety Code

§ 7191.5(g) (West Supp. 1996) 9

Cal. Pen. Code

§ 401 (West 1988) 11

TABLE OF AUTHORITIES – Continued

Page

Colo. Rev. Stat.

§ 15-18-112(1) (West 1987) 9

§ 18-3-104(1)(b) (Supp. 1995) 12

Conn. Gen. Stat. Ann.

§ 19a-575 (West Supp. 1996) 10

§ 53a-56(a)(2) (West 1994) 12

D.C. Code Ann.

§ 6-2430 (1989) 10

Del. Code Ann.

tit. 11, § 645 (1995) 12

Del. Session Laws

Act of July 12, 1982, § 3, 63 Del. Laws 821 (1981) 10

Fla. Stat. Ann.

§ 765.309(1) (West Supp. 1996) 9

§ 782.08 (West 1992) 12

Ga. Code Ann.

§ 31-32-11(b) (1996) 9

§ 16-5-5(b) (1996) 12

Haw. Rev. Stat.

§ 327D-13 (Supp. 1992) 9

Idaho Code

§ 39-152 (Supp. 1996) 10

TABLE OF AUTHORITIES – Continued

Page

Ill. Comp. Ann. Stat.

ch. 755, § 35/9(f) (Smith-Hurd 1992) 9

ch. 755, § 40/50 (Smith-Hurd 1992)..... 10

ch. 720, 5/12-31(a)(2) (Smith-Hurd Supp. 1996)..... 12

Ind. Code Ann.

§ 16-36-4-19 (West Supp. 1996) 9

§§ 16-36-1-12(c), 16-36-1-13 (West Supp. 1996) 10

§ 30-5-5-17(b) (West 1994)..... 10

§ 35-42-1-2.5(b) (West Supp. 1996) 12

Iowa Code Ann.

§ 144B.12.2 (West Supp. 1996)..... 10

§ 144A.11.6 (West 1989)..... 10

§§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session 12

Kan. Stat. Ann.

§§ 65-28,109 (1992) 10

§ 21-3406 (1995)..... 12

Ky. Rev. Stat. Ann.

§ 311.639 (Michie 1995)..... 10

§ 216.302 (Michie 1995)..... 12

La. Rev. Stat. Ann.

§ 40:1299.58.10(A) (West 1992) 10

§ 14:32.12 (West Supp. 1996) 12

TABLE OF AUTHORITIES – Continued

Page

Mass. Gen. Laws Ann.

ch. 201D, § 12 (West Supp. 1996)..... 10

Md. Code Ann.

§ 5-611(c) (1984)..... 10

Me. Rev. Stat. Ann.

tit. 18-A, § 5-813(c) (West Supp. 1995)..... 10

tit. 17-A, § 204 (West 1983) 12

Mich. Comp. Laws Ann.

§ 700.496(20) (West 1995) 10

Minn. Stat. Ann.

§ 145B.14 (West Supp. 1996)..... 10

§ 609.215 (West 1987 and Supp. 1996)..... 12

Miss. Code Ann.

§ 41-41-117(2) (1993)..... 10

§ 97-3-49 (1994) 12

Mo. Ann. Stat.

§ 459.055(5) (West 1992) 10

§ 565.023(1)(2) (West Supp. 1996)..... 12

Mont. Code Ann.

§ 50-9-205(7) (1995)..... 10

§ 45-5-105 (1995) 12

TABLE OF AUTHORITIES – Continued

Page

Neb. Rev. Stat. Ann.
§ 20-412(7) (Michie 1991) 10
§ 28-307 (Michie 1995) 12
Nev. Rev. Stat. Ann.
§ 449.670(2) (Michie 1991) 10
N.H. Rev. Stat. Ann.
§ 137-H:13 (1996) 10
§ 630:4 (1996) 12
N.J. Stat. Ann.
§ 26:2H-54(d)-(e) (West 1996) 10
§ 2C:11-6 (West 1995) 12
N.M. Stat. Ann.
§ 24-7A-13(C) (Michie Supp. 1995) 10
§ 30-2-4 (Michie 1994) 12
New York Penal Law
§ 120.30 (McKinney 1987) 6, 12, 22
§ 125.15(3) (McKinney 1987) 6, 12, 22
New York Public Health Law Article 29-B
§ 2960-2979 15
§ 2962 16
§ 2964 15

TABLE OF AUTHORITIES – Continued

Page

New York Public Health Law Article 29-C
§ 2981 15
§ 2989(3) (McKinney 1993) 10, 15
§§ 2980-2994 15
N.C. Gen. Stat.
§ 90-320(b) (1993) 10
N.D. Cent. Code
§ 23-06.5-01 (1991) 10
§ 23-06.4-01 (1991) 10
§ 12.1-16-04 (Supp. 1995) 12
Ohio Rev. Code Ann.
§ 2133.12(D) (Anderson 1994) 10
Okla. Stat. Ann.
tit. 63, § 3101.12(G) (West Supp. 1996) 10
tit. 21, §§ 813, 814, 815 (West 1983) 12
Or. Rev. Stat.
§ 127.800 *et seq.* (1996) 12
§ 163.125(1)(b) (1993) 12
P.R. Laws Ann.
tit. 33, § 4009 12
Pa. Cons. Stat. Ann.
tit. 20, § 5402(b) (West Supp. 1996) 10
tit. 18, § 2505(b) (West 1983) 12

TABLE OF AUTHORITIES – Continued

Page

R.I. Gen. Laws

§ 23-4.10-9(f) (Supp. 1995) 10

§ 23-4.11-10(f) (Supp. 1995) 10

R.I. Pub. Act

96-133, *to be codified as* R.I. Gen. Stat., tit. 11, ch. 60..... 12

S.C. Code Ann.

§ 44-77-130 (Law Co-op. Supp. 1995)..... 10

S.D. Codified Laws Ann.

§ 34-12D-20 (Michie 1994)..... 10

§ 22-16-37 (Michie 1988) 12

Tenn. Code Ann.

§ 39-13-216 (Supp. 1995) 12

Tex. Health & Safety Code Ann.

§ 672.020 (West 1992)..... 10

Tex. Penal Code Ann.

§ 22.08 (West 1994) 12

Utah Code Ann.

§ 75-2-1118 (1993) 10

V.I. Code Ann.

tit. 14, § 2141..... 12

Va. Code Ann.

§ 54.1-2990 (Michie 1994) 10

TABLE OF AUTHORITIES – Continued

Page

W.Va. Code

§ 16-30-10 (1995) 10

§ 16-30C-14 (1995)..... 10

Wash. Rev. Code Ann.

§ 70.122.100 (West 1996 Supp.) 10

§ 9A.36.060 (West 1988)..... 12

Wis. Stat. Ann.

§ 154.11(6) (West 1989) 10

§ 940.12 (West 1996) 12

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§ 3-5-211 (Supp. 1996) 10

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TABLE OF AUTHORITIES – Continued

Page

New York State Task Force Report, *When Death is Sought – Assisted Suicide and Euthanasia in the Medical Context* (May 1994) 20, 21, 22, 29

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INTEREST OF THE *AMICI* STATES

The decision below represents a return to an era, long since past, when the principles of federalism were all but eliminated by the mistaken notion that the Fourteenth Amendment authorizes courts to substitute their judgment for that of the States in matters of economic and social welfare. In an opinion which significantly departs from this Court's present-day equal protection jurisprudence, the Second Circuit has declared that New York's prohibition of assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment to the extent that it prohibits a physician from prescribing a lethal dose of medication for self-administration by a mentally-competent, terminally ill patient in the final stages of his or her illness. *Quill v. Vacco*, 80 F.3d 716, 731 (2d Cir. 1996) (hereinafter "*Quill*"), *cert. granted*, ___U.S.___ (1996 WL 282544) (1996). In so holding, the Second Circuit found that New York's prohibition of assisted suicide did not further, and thus was not rationally related to, ***any*** legitimate state interest. *Quill*, 80 F.3d at 729-731.

More troubling than the serious flaws in the Court's analysis is the impact of its holding which negates the ability of the States to protect the lives of their citizens and, at the same time, undercuts accepted understandings of federalism. The protection and preservation of human life is, without question, the quintessential duty and responsibility of the sovereign States in our federal system of government. The power of the States to fulfill this most important of responsibilities, through the exercise of the police power, is likewise unquestionable.[1] Indeed, as Justice Harlan observed in his famous dissent in *Lochner v. New York*, "[a]ll the cases agree that . . . [the States' police] power extends at least to the protection of the lives, the health, and the safety of the public against the injurious exercise by any citizen of his own

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[1] "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States, respectively, or to the people." U.S. Const. amend. X.

rights."[2] *Lochner v. New York*, 198 U.S. 45, 65 (1905) (Harlan, J., dissenting). "[A]ll states provide for the involuntary commitment of persons who may harm themselves as the result of mental illness, and a number of states allow the use of nondeadly force to thwart suicide attempts." *People v. Kevorkian*, 447 Mich. 436, 479, 527 N.W.2d 714, 732 (1994) (footnotes omitted), *cert. denied*, 115 S.Ct. 1795 (1995). The overwhelming majority of States impose criminal penalties on one who assists another to commit suicide. *See* n.19, *infra*.

At stake in this case are, first and foremost, the lives of the people, both those who wish to die and those who wish to live no matter what their circumstances. Also at stake is the sovereign power of the States to protect and preserve those lives without a federal requirement that the State "make judgments about the 'quality' of life that a particular individual may enjoy, . . . " *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 282 (1990). The Court's decision in this case will directly affect the people of all the States of the Union. It will also determine whether "the States *as States* have [any] legitimate interests which the National Government is bound to respect even though its laws are supreme." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 581 (1985) (O'Connor, J., dissenting) (italics original, citation omitted, insert added).

SUMMARY OF ARGUMENT

The question presented in this case is whether the State of New York's prohibition of assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment. The resolution of this question will have profound implications for the continued viability of the States in our federal system of

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[2] "The powers delegated by the proposed Constitution to the federal government are few and defined. Those which are to remain in the State governments are numerous and indefinite. . . . The powers reserved to the several states will extend to all the objects which, in the ordinary course of affairs, concern the lives, liberties, and properties of the people, and the internal order, improvement, and prosperity of the State." James Madison, *The Federalist* No. 45, at 2:82 (1788).

government. Over a century ago, this Court, describing the dual sovereignty of the States and Federal Government, declared that:

> The preservation of the States, and the maintenance of their governments, are as much within the design and care of the Constitution as the preservation of the Union and the maintenance of the National government. The Constitution, in all its provisions, looks to an indestructible Union, composed of indestructible States.[3]

A proper balance of power between the States and National government "preserves to the people numerous advantages", not the least of which "is a check on abuses of government power." *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991). However, as Justice O'Connor, writing for the majority in *Gregory*, cautioned, "[t]hese twin powers will act as mutual restraints only if both are credible. In the tension between federal and state power lies the promise of liberty." *Id.*, at 459. While the question presented in this case is one of equal protection,[4] the real question is whether the States will continue to retain their sovereign authority in a system in which "[t]he Federal Government holds a decided advantage . . . the Supremacy Clause." *Id.*, at 460.

In the case below, the Second Circuit declared that New York's prohibition of assisted suicide violates the Equal Protection Clause of the Fourteenth Amendment. *Quill*, 80 F.3d

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[3] *Texas v. White*, 7 Wall. 700, 725 (1869), *quoting Lane County v. Oregon*, 7 Wall. 71, 76 (1869). *See also Tafflin v. Levitt*, 493 U.S. 455, 458 (1990) ("We begin with the axiom that, under our federal system, the States possess sovereignty concurrent with that of the Federal Government, subject only to limitations imposed by the Supremacy Clause.")

[4] *San Antonio School District v. Rodriguez*, 411 U.S. 1, 44 (1973) ("It must be remembered, also, that every claim arising under the Equal Protection Clause has implications for the relationship between national and state power under our federal system. Questions of federalism are always inherent in the process of determining whether a State's laws are to be accorded the traditional presumption of constitutionality, or are to be subjected instead to rigorous judicial scrutiny.").

at 731. The centerpiece of the Second Circuit's opinion was its conclusion that terminally ill persons on life support who wish to "hasten death"[5] by directing the withdrawal of such systems are similarly situated with others who wish to "hasten death by self-administering prescribed drugs." *Quill*, 80 F.3d at 729. However, "those courts that have found a right to refuse to begin or to continue life-sustaining medical treatment have done so only after concluding that such refusal is wholly different from the act of suicide."[6] Legislatures in forty-seven of the fifty States (including New York) have likewise recognized this fundamental distinction. *See* ns. 14-16, *infra*. Notwithstanding this overwhelming authority to the contrary, the Second Circuit erroneously concluded the two situations are indistinguishable. *Quill*, 80 F.3d at 729. By doing so, it created a class of similarly situated persons where, in fact, none existed. As will be seen, the Second Circuit's failure to recognize this critical distinction infected its constitutional analysis, contributed to its misplaced reliance on right-to-refuse treatment cases, and led directly to its ultimate erroneous conclusion.

In the case below, the Second Circuit correctly found that New York's statutes prohibiting assisted suicide neither impinge upon fundamental rights nor create suspect classifications and, thus, that the rational-basis standard of review

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[5] There is a danger in using euphemistic language such as "hasten death" when referring to the act of suicide. The term "hasten death" incorrectly implies a natural process being hurried along as opposed to the intentional act of terminating life artificially. Such language has a tendency to obfuscate the reality of the important questions which end-of-life cases generally present. *See People v. Kevorkian*, 447 Mich. 436, 464 n.27, 527 N.W.2d 714, 725 n.27 (1994), *cert. denied*, 115 S.Ct. 1795 (1995), and *Cruzan v. Harmon*, 760 S.W.2d 408, 412 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

[6] *People v. Kevorkian*, 447 Mich. 436, 480, 527 N.W.2d 714, 732 (1994) (footnote omitted), *cert. denied*, 115 S.Ct. 1795 (1995). *See* n.12, *infra*, and cases cited therein. *But see Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996), *cert. granted*, ___ U.S. ___ (1996 WL 411596) (1996).

applied. *Quill*, 80 F.3d at 726-727. However, it failed to properly apply that standard in accordance with the clear precedents of this Court. Simply put, while the Second Circuit invoked rational-basis language, that was not the standard it applied.

The Second Circuit's analysis was further flawed by the improper insertion of quality-of-life considerations which it used to discount the State's important interests in the protection and preservation of human life. *Quill*, 80 F.3d at 729-730. In addition to being contrary to the Court's holding in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 262, 282 (1990), such an analysis also disregards the irrefutable principle that all lives, from beginning to end and irrespective of physical or mental condition, are under the full protection of the law.

Finally, the Second Circuit suggested several alternative methods by which the State of New York could achieve its legitimate objectives. However, the fact that a State may, if it chooses, seek to achieve its legitimate objectives through other means does not, in any way, establish that the means actually selected are either irrational or arbitrary. In short, had the Second Circuit applied the rational-basis standard of review in accordance with the precedents of this Court, New York's prohibition of assisted suicide clearly would have passed constitutional muster.

ARGUMENT

I. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE DOES NOT TREAT SIMILARLY SITUATED PERSONS IN AN UNEQUAL MANNER

The Equal Protection Clause "is essentially a direction that all persons similarly situated should be treated alike." *Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 440 (1985) (citation omitted). In order to establish an equal protection violation, there must be a showing that the State has adopted a classification which treats similarly situated

persons in an unequal manner.[7] That cannot possibly be established here. First, under the plain language of the statutes at issue, *all* persons, regardless of their circumstances, are prohibited from intentionally aiding another person to attempt or commit suicide.[8] Thus, on their face, the challenged statutes create no classifications at all.[9] Second, neither statute has been applied in this case, *i.e.*, none of the respondents have been charged with any violation of section 125.15(3) or 120.30.[10] Thus, to the extent that New York law classifies at all, that classification is clearly neutral.[11]

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[7] *Yick Wo v. Hopkins*, 118 U.S. 356, 373-374 (1886). *See also In re Eric J.*, 25 Cal.3d 522, 530, 159 Cal.Rptr. 317, 320 (1979) ("The first prerequisite to a meritorious claim under the equal protection clause is a showing that the state has adopted a classification that affects two or more *similarly situated* groups in an unequal manner. [italics original, citation and footnote omitted]").

[8] Section 125.15 of the New York Penal Law, entitled "Manslaughter in the second degree," provides in pertinent part that "A person is guilty of manslaughter in the second degree when: . . . (3) He intentionally causes or aids another person to commit suicide. Manslaughter in the second degree is a class C felony." N.Y. Penal Law § 125.15(3) (McKinney 1987). Section 120.30 of the New York Penal Law, entitled "Promoting a suicide attempt," provides that "A person is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide. Promoting a suicide attempt is a class E felony." N.Y. Penal Law § 120.30 (McKinney 1987).

[9] To the extent that the Second Circuit's opinion can be viewed as being based on the concept of overbreadth, *i.e.*, that the challenged statutes sweep too broadly, it is plainly inconsistent with previous holdings of this Court. While a finding of overbreadth or " 'overreaching' " may be significant where First Amendment considerations are present, the concept has no application here. *Dandridge v. Williams*, 397 U.S. 471, 484-485 (1970).

[10] While a grand jury proceeding was instituted against one of the respondents in this case, Dr. Quill, no indictment was returned. *Quill v. Koppell*, 870 F.Supp. 78, 82 (S.D.N.Y. 1994), *aff'd in part and rev'd in part sub nom. Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

[11] Of course, the fact that a neutral statute may have a disproportionate negative impact on a particular group does not, standing alone, establish a violation of equal protection. *Personnel Administrator of Massachusetts v. Feeney*, 442 U.S. 256, 271-273 (1979). *See also Washington v. Davis*, 426 U.S. 229, 242 (1976) ("[W]e have not held that a law, neutral on its face and serving ends otherwise within the power of government to pursue, is invalid under the Equal Protection Clause simply because it may affect a greater proportion of one race than of another.") Rather, in such a situation it must also be shown that the affected group has historically been the victim of discrimination and, further, that the statute was enacted for a discriminatory purpose. *Feeney*, 442 U.S. at 273-274. That cannot possibly be established here. In the case below, the Second Circuit did not find that terminally ill persons had experienced "a history of purposeful unequal treatment" (*San Antonio School District v. Rodriguez*, 411 U.S. 1, 28 (1973)), or that New York's prohibition of assisted suicide was enacted for the purpose of discriminating against terminally ill persons. "[T]he Fourteenth Amendment guarantees equal laws, not equal results." *Feeney*, at 273.

In *Quill*, the Second Circuit found a classification created not by the plain language of the challenged statutes, or by their application in a particular case, but rather based on its conclusion that the refusal of unwanted life-sustaining medical treatment is the equivalent of suicide and assisted suicide. *Quill*, 80 F.3d at 729. That conclusion, the centerpiece of the Second Circuit's opinion, was error.

A. The Refusal of Unwanted Life-Sustaining Medical Treatment Is Not The Equivalent Of Suicide Or Assisted Suicide, And Thus, New York's Prohibition Of Assisted Suicide Does Not Create A Class of Similarly Situated Persons

The Equal Protection Clause permits the States to determine, in the first instance, which persons are similarly situated and which are not. Indeed, it is well-settled that "[t]he initial discretion to determine what is 'different' and what is 'the same' resides in the legislatures of the States." *Plyer v. Doe*, 457 U.S. 202, 215 (1982). In the instant case, the States have made that determination: terminally ill persons who refuse unwanted life-sustaining medical treatment

are not similarly situated with other persons who wish to commit suicide or assisted suicide.

In landmark case of *In re Quinlan*, the New Jersey Supreme Court recognized that there is "a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death." *In re Quinlan*, 70 N.J. 10, 43, 355 A.2d 647, 665, *cert. denied*, 429 U.S. 922 (1976). Since *Quinlan*, courts which have recognized a right to refuse unwanted life-sustaining medical treatment have, at the same time, recognized that such refusal is fundamentally different from the act of suicide.[12] A typical example of this can be found in *People v. Kevorkian* wherein the Michigan Supreme Court stated that:

> [P]ersons who opt to discontinue life-sustaining

[12] *See, e.g., Satz v. Perlmutter*, 362 So.2d 160, 162-163 (Fla. DCA 1978), *aff'd*, 379 So.2d. 359 (Fla. 1980); *Von Holden v. Chapman*, 87 A.D.2d 66, 450 N.Y.S.2d 623, 627 (1982) ("essential dissimilarity" between right to decline medical treatment and any right to end one's life); *In re Conroy*, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985) ("[D]eclining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were to eventually occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. [footnote omitted]"); *Bouvia v. Superior Court*, 179 Cal.App.3d 1127, 1145, 225 Cal.Rptr. 297, 306 (1986); *Bartling v. Superior Court*, 163 Cal.App.3d 186, 196, 209 Cal.Rptr. 220, 225-226 (1984); *People v. Adams*, 216 Cal.App.3d 1431, 1440, 265 Cal.Rptr. 568, 573-574 (1990); *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1619-1623, 4 Cal.Rptr.2d 59, 61-64 (1992) and cases cited therein; *Thor v. Superior Court*, 5 Cal.4th 725, 742, 21 Cal.Rptr.2d 357, 367-368 (1993) ("[A] necessary distinction exists between a person suffering from a serious life-threatening or debilitating injury who rejects medical intervention that only prolongs but never cures the affliction and an individual who deliberately sets in motion a course of events aimed at his or her own demise and attempts to enlist the assistance of others."); *DeGrella v. Elston*, 858 S.W.2d 698, 706-707 (Ky. 1993). *See also* Thomas J. Marzen, *et al.*, *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1, 10 n.34 (1985), and cases cited therein.

> medical treatment are not, in effect, committing suicide. There is a difference between choosing a natural death summoned by an uninvited illness or calamity, and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying.[13]

Likewise, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), this Court "assume[d] that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition" but, at the same time, recognized Missouri's important interest in the protection and preservation of human life, noting that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 279-280 (footnote omitted). Plainly, the majority in *Cruzan* had no difficulty at all distinguishing the right to refuse unwanted life-sustaining medical treatment from suicide and assisted suicide.

Today, forty-seven state legislatures also make the fundamental distinction between the refusal of unwanted life-sustaining medical treatment and the acts of suicide and assisted suicide in their natural death/living will statutes,[14] or their

[13] *People v. Kevorkian*, 447 Mich. 436, 472-473, 527 N.W.2d 714, 728-729 (1994) (*citing McKay v. Bergstedt*, 106 Nev. 808, 820, 801 P.2d 617 (1990)), *cert. denied*, 115 S.Ct. 1795 (1995). *See also* Yale Kamisar, *Are Laws against Assisted Suicide Unconstitutional?*, 23 Hastings Center Report, No. 3, 32, 33 (1993) ("The only right or liberty that the *Karen Ann Quinlan* case and subsequent so-called 'right to die' rulings have established is the right under certain circumstances to be disconnected from artificial life support systems or, as many have called it, the right to die *a natural death*. [italics original]").

[14] Ala. Code § 22-8A-10 (1990); Alaska Stat. § 18.12.080(f) (Michie 1994); Ariz. Rev. Stat. Ann. § 36-3210 (West Supp. 1995); Ark. Code Ann. § 20-17-210(g) (Michie 1991); Cal. Health & Safety Code § 7191.5(g) (West Supp. 1996); Colo. Rev. Stat. § 15-18-112(1) (West 1987); Fla. Stat. Ann. § 765.309(1) (West Supp. 1996); Ga. Code Ann. § 31-32-11(b) (1996); Haw. Rev. Stat. § 327D-13 (Supp. 1992); Ill. Comp. Ann. Stat. ch. 755, § 35/9(f) (Smith-Hurd 1992); Ind. Code Ann. § 16-36-4-19 (West

durable power of attorney for health care acts,[15] or both.[16] This fundamental distinction, now a national consensus, must today be considered a firmly established principle of American jurisprudence.

The rationale supporting this fundamental distinction is straightforward and based on obvious factual differences

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Supp. 1996); Iowa Code Ann. § 144A.11.6 (West 1989); Kan. Stat. Ann. § 65-28,109 (1992); Ky. Rev. Stat. Ann. § 311.639 (Michie 1995); La. Rev. Stat. Ann. § 40:1299.58.10(A) (West 1992); Me. Rev. Stat. Ann. tit. 18-A, § 5-813(c) (West Supp. 1995); Md. Health-Gen. Code Ann. § 5-611(c) (1994); Minn. Stat. Ann. § 145B.14 (West Supp. 1996); Miss. Code Ann. § 41-41-117(2) (1993); Mo. Ann. Stat. § 459.055(5) (West 1992); Mont. Code Ann. § 50-9-205(7) (1995); Neb. Rev. Stat. Ann. § 20-412(7) (Michie 1995); Nev. Rev. Stat. Ann. § 449.670(2) (Michie 1991); N.H. Rev. Stat. Ann. § 137-H:13 (1996); N.C. Gen. Stat. § 90-320(b) (1993); N.D. Cent. Code § 23-06.4-01 (1991); Ohio Rev. Code Ann. § 2133.12(D) (Anderson Supp. 1995); Okla. Stat. Ann. tit. 63, § 3101.12(G) (West Supp. 1996); Pa. Cons. Stat. Ann. tit. 20, § 5402(b) (West Supp. 1996); R.I. Gen. Laws § 23-4.11-10(f) (Supp. 1995); S.C. Code Ann. § 44-77-130 (Law Co-op. Supp. 1996); S.D. Codified Laws Ann. § 34-12D-20 (Michie 1994); Tex. Health & Safety Code Ann. § 672.020 (West 1992); Utah Code Ann. § 75-2-1118 (1993); Va. Code Ann. § 54.1-2990 (Michie 1994); Wash. Rev. Code Ann. § 70.122.100 (West Supp. 1996); W.Va. Code § 16-30-10 (1995), *see also* § 16-30C-14 (1995) (DNR orders); Wis. Stat. Ann. § 154.11(6) (West 1989); Wyo. Stat. § 35-22-109 (Michie 1994). *See also* D.C. Code Ann. § 6-2430 (1989).

[15] Act of July 12, 1982, § 3, 63 Del. Laws 821 (1981); Idaho Code § 39-152 (Supp. 1996) (DNR orders); Ill. Comp. Stat. Ann. ch. 755, § 40/50 (Smith-Hurd 1992); Ind. Code Ann. §§ 16-36-1-12(c), 16-36-1-13 (West Supp. 1996), *see also* § 30-5-5-17(b) (West 1994); Iowa Code Ann. § 144B.12.2 (West Supp. 1996); Mass. Gen. Laws Ann. ch. 201D, § 12 (West Supp. 1996); Mich. Comp. Laws Ann. § 700.496(20) (West 1995); N.Y. Pub. Health Law § 2989(3) (McKinney 1993); N.D. Cent. Code § 23-06.5-01 (1991); R.I. Gen. Laws § 23-4.10-9(f) (Supp. 1995); Wyo. Stat. § 3-5-211 (Michie Supp. 1996).

[16] *See* notes 14 and 15, *supra*. *See also* Conn. Gen. Stat. Ann. § 19a-575 (West Supp. 1996) (form declarations); N.J. Stat. Ann. § 26:2H-54(d)-(e) (West 1996) (legislative findings); N.M. Stat. Ann. § 24-7A-13(C) (Michie Supp. 1995).

between the two situations. When a terminally ill person accepts life-sustaining treatment, he or she is authorizing the invasion of bodily integrity which necessarily accompanies that treatment. The fact that this class of persons must sacrifice their bodily integrity in order to continue living plainly demonstrates they are not similarly situated with any other class. Furthermore, "[a] person may refuse life-sustaining medical treatment because the treatment itself is a violation of bodily integrity."[17] In sharp contrast, suicide and assisted suicide do not implicate a person's right to protect bodily integrity or right to refuse unwanted medical treatment.

Our Nation's history and tradition fully supports the States' determination that these two situations are not the same. The right to refuse unwanted medical treatment is derived from the common-law doctrine of informed consent which embodies the "notion of bodily integrity." *Cruzan*, 497 U.S. at 269 and 270. As the Court observed in *Cruzan*, "[t]he informed consent doctrine has become firmly entrenched in American tort law." *Id.* In sharp contrast, opposition to suicide is deeply rooted in our Nation's history and tradition,[18] and assisted suicide remains a crime in the overwhelming majority of States.[19]

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[17] *People v. Kevorkian*, 447 Mich. 436, 480 n.59, 527 N.W.2d 714, 732 n.59 (1994), *cert. denied*, 115 S.Ct. 1795 (1995).

[18] *See In re Joseph G.*, 34 Cal.3d 429, 433-435, 194 Cal.Rptr. 163, 165 (1983) (reviewing development of the law with respect to suicide and related crimes); *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 294-295 (1990) (Scalia, J., concurring) (reviewing our Nation's historical and traditional opposition to suicide and assisted suicide); Thomas J. Marzen, *et al.*, *Suicide, A Constitutional Right?*, 24 Duq. L. Rev. 1, 100 (1985) (concluding that "the weight of authority in the United States, from colonial days through at least the 1970's has demonstrated that the predominant attitude of society and the law has been one of opposition to suicide.").

[19] The following States, plus Puerto Rico and the Virgin Islands, expressly prohibit assisted suicide by statute: Alaska Stat., § 11.41.120(a)(2) (Michie 1989); Ariz. Rev. Stat. Ann., § 13-1103(A)(3) (West Supp. 1995); Ark. Stat. Ann., § 5-10-104(a)(2) (Michie 1993); Cal.

In summary, suicide and assisted suicide are so obviously different from the refusal of unwanted medical treatment, and its legal underpinnings, that persons exercising the right to refuse such treatment simply cannot be considered similarly situated with those who wish to commit suicide or assisted suicide. By failing to recognize the obvious factual differences between the two situations, and our Nation's history and tradition with respect to each, the Second Circuit created a class of similarly situated persons where, in fact,

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Pen. Code, § 401 (West 1988); Colo. Rev. Stat., § 18-3-104(1)(b) (Supp. 1995); Conn. Gen. Stat. Ann., § 53a-56(a)(2) (West 1994); Del. Code Ann., tit. 11, § 645 (1995); Fla. Stat. Ann., § 782.08 (West 1992); Ga. Code Ann. § 16-5-5(b) (1996); Ill. Comp. Stat. Ann., ch. 720, 5/12-31(a)(2) (Smith-Hurd Supp. 1996); Ind. Stat. Ann., § 35-42-1-2.5(b) (West Supp. 1996); Iowa Code, §§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session; Kan. Stat. Ann., § 21-3406 (1995); Ky. Rev. Stat. Ann., § 216.302 (Michie 1995); La. Rev. Stat. Ann., § 14:32.12 (West Supp. 1996); Me. Rev. Stat. Ann., tit. 17-A, § 204 (West 1983); Minn. Stat. Ann., § 609.215 (West 1987 and Supp. 1996); Miss. Code Ann., § 97-3-49 (1994); Mo. Ann. Stat., § 565.023(1)(2) (West Supp. 1996); Mont. Code Ann., § 45-5-105 (1995); Neb. Rev. Stat. Ann., § 28-307 (Michie 1995); N.H. Rev. Stat. Ann., § 630:4 (1996); N.J. Stat. Ann., § 2C:11-6 (West 1995); N.M. Stat. Ann., § 30-2-4 (Michie 1994); N.Y. Penal Law, §§ 120.30, 125.15(3) (McKinney 1987); N.D. Cent. Code, § 12.1-16-04 (Supp. 1995); Okla. Stat. Ann., tit. 21, §§ 813, 814, 815 (West 1983); Pa. Cons. Stat. Ann., tit. 18, § 2505(b) (West 1983); P.R. Laws Ann., tit. 33, § 4009; R.I. Pub. Act 96-133, *to be codified as* R.I. Gen. Stat., tit. 11, ch. 60; S.D. Codified Laws Ann., § 22-16-37 (Michie 1988); Tenn. Code Ann., § 39-13-216 (Supp. 1995); Tex. Penal Code Ann., § 22.08 (West 1994); V.I. Code Ann., tit. 14, § 2141; Wash. Rev. Code Ann., § 9A.36.060 (West 1988); and Wis. Stat. Ann., § 940.12 (West 1996). *See also* Or. Rev. Stat. § 163.125(1)(b) (1993) (prohibiting assisted suicide generally), *but see* Or. Rev. Stat. § 127.800 *et seq.* (1996) (permitting physician-assisted suicide in certain circumstances). The following states impose criminal penalties by case law for assisting a suicide: *Commonwealth v. Mink*, 123 Mass. 422, 428-429 (1877); *People v. Kevorkian*, 447 Mich. 436, 493-497, 527 N.W.2d 714, 738-739 (1994), *cert. denied*, 115 S.Ct. 1795 (1995); *Blackburn v. State*, 23 Ohio St. 146, 163 (1872); *State v. Jones*, 86 S.C. 17, 22, 47, 67 S.E. 160, 162, 165 (1910); and *State v. Willis*, 255 N.C. 473, 477, 121 S.E.2d 854, 856-857 (1961).

none existed. "The Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." *Tigner v. Texas*, 310 U.S. 141, 147 (1940).

B. The New York Authorities Relied Upon By The Second Circuit Do Not Support Its Conclusion That New York Has Recognized A Right To Commit Suicide Or "Hasten Death"

Even the New York authorities relied upon by the Second Circuit do not support its conclusion that New York has recognized a right to commit suicide, or as the Second Circuit phrased it, a right to "hasten death." The first case cited by the Second Circuit in its effort to create a bridge between the right to refuse medical treatment and a right to "hasten death" was *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 105 N.E. 92 (1914). *Quill*, 80 F.3d at 727. However, *Schloendorff* is simply an "informed consent" case, the pertinent portion of which this Court discussed in *Cruzan* as follows:

> Justice Cardozo, while on the Court of Appeals of New York, aptly described this doctrine [of informed consent]: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914).

Cruzan, 497 U.S. at 269. Plainly *Schloendorff*, which simply recognizes the doctrine of informed consent, does not support a right to "hasten death." Neither did Justice Cardozo.[20]

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[20] Margaret E. Hall, *Selected Writings of Benjamin Nathan Cardozo*, Law and Literature, III, *What Medicine Can Do for Laws*, 371, 388-390 (1947) ("Every now and then there crops up in popular journals a discussion of the problem of euthanasia. The query is propounded whether the privilege should be accorded to a physician of putting a patient painlessly out of the world when there is an incurable disease, agonizing

The Second Circuit then cited *Matter of Storar* and *Eichner v. Dillon* (decided together), 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981), for the proposition that "[i]n both these cases, the New York Court of Appeals recognized the right of a competent, terminally-ill patient to hasten his death upon proper proof of his desire to do so." *Quill*, 80 F.3d at 727. *Storar* and *Eichner*, however, are both right to refuse treatment cases. The phrase "hasten his death" incorrectly implies that the New York Court of Appeals approved not only the right to refuse unwanted medical treatment, but also the act of suicide. It did not. Moreover, in relying on these cases, the Second Circuit ignored the far more relevant part of the majority opinion which recognized that "[t]he State has a legitimate interest in protecting the lives of its citizens. . . . It may, by statute, prohibit them from engaging in specified activities, including medical procedures which are inherently hazardous to their lives." *Matter of Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71 (citation omitted, insert added), *cert. denied*, 454 U.S. 858 (1981).

Further review of the majority opinion reveals even more evidence that the New York Court of Appeals did not impliedly approve of suicide (*i.e.*, "hastening death"). First, the New York Court of Appeals specifically noted that the State's interest in preventing suicide was *not* implicated in the *Eichner* case. *Matter of Storar*, 52 N.Y.2d at 377 n.6. Second, noting the need for judicial restraint, the majority found it unnecessary on the facts of the cases before it to address the dissent's endorsement of a limited form of passive euthanasia. *Matter of Storar*, 52 N.Y.2d at 370 n.2. In view of the foregoing, the Second Circuit's reliance on *Storar* and *Eichner* was clearly misplaced.

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suffering, and a request by the sufferer for merciful release. No such privilege is known to our law, which shrinks from any abbreviation of the span of life, shaping its policy in that regard partly under the dominance of the precepts of religion and partly in the fear of error or abuse. Just as a life may not be shortened, so its value must be held as equal to that of any other, the mightiest or the lowliest.").

The Second Circuit also relied on *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337 (1986), for the proposition that the New York Court of Appeals had "recognized the right to bring on death by refusing medical treatment not only as a fundamental common-law right but also as coextensive with [a] patient's liberty interest protected by the due process clause of our State Constitution." *Quill*, 80 F.3d at 727 (internal quotes and citation omitted, insert original). Again, this is incorrect. In *Rivers*, the New York Court of Appeals did not mention any "right to bring on death," a phrase which again incorrectly implies approval of the act of suicide. Rather, the right which the court recognized, as evidenced from the text of the opinion itself, was *the right to refuse unwanted medical treatment*. *Rivers*, 67 N.Y.2d at 493.

The Second Circuit also relied on both Article 29-B of New York Public Health Law, entitled "Orders Not to Resuscitate", sections 2960-2979, and Article 29-C, entitled "Health Care Agents and Proxies", sections 2980-2994, for the proposition that "the New York legislature [has] placed its imprimatur upon the right of competent citizens to hasten death by refusing medical treatment and by directing physicians to remove life-support systems already in place." *Quill*, 80 F.3d at 727 (insert added). Again, this is incorrect. As a review of these statutes plainly reveals, the New York legislature did not recognize any right to "hasten death," rather, it recognized the right to refuse medical treatment.[21] Moreover, in relying on these statutes, the Second Circuit ignored the far more relevant statute, New York Public Health Law, Article 29-C, § 2989(3), which specifically provides that:

> This article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to

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[21] *See, e.g.*, New York Public Health Law, Article 29-B, § 2964 (recognizing right of adult with capacity to consent to an order not to resuscitate), and Article 29-C, § 2981 (allowing for appointment of an agent "to make health care decisions on the principal's behalf").

> permit an agent to consent to any act or omission to which the principal could not consent under law.[22]

This statute directly contradicts the Second Circuit's contention that the New York legislature has either expressly or impliedly approved of suicide or assisted suicide. Plainly, it has not. In summary, none of the New York authorities discussed above support the contention that the State of New York has recognized a right to commit suicide or, as the Second Circuit phrased it, a right to "hasten death." Rather, what the State of New York has recognized is the right to refuse unwanted medical treatment, regardless of the consequences of that refusal.

The final authority relied upon by the Second Circuit in its effort to equate the withdrawal of life-sustaining medical treatment with the act of suicide is *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). However, like its reliance on New York law, that reliance is entirely misplaced. While the Second Circuit discussed several portions of the *Cruzan* opinion at length, it ignored the far more relevant portion of the opinion for present purposes, *i.e.*, the recognition by the majority that even in the face of a right to refuse medical treatment, the State may properly assert important interests in the protection and preservation of human life, and in the prevention of both suicide and assisted suicide. *Cruzan*, 497 U.S. at 280. In summary, none of the authorities relied upon by the Second Circuit support its attempt to create a bridge between the right to refuse unwanted medical treatment, including that necessary to sustain life, and a right to commit suicide or assisted suicide.

II. NEW YORK'S PROHIBITION OF ASSISTED SUICIDE IS RATIONALLY RELATED TO NUMEROUS IMPORTANT GOVERNMENTAL OBJECTIVES

Should this Court find a state-determined class of similarly situated persons, it then becomes necessary to test

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[22] *See also* New York Public Health Law, Article 29-B, § 2962 (creating a presumption in favor of resuscitation, thus, further evidencing New York's strong state policy in favor of preserving life).

whether that classification "has been drawn in such a manner as to bear some rational relationship to a legitimate state end."[23] Part of the answer to this question "lies in remembering that our Constitution is an instrument of federalism" and that "maintenance of the principles of federalism is a foremost consideration in interpreting any of the pertinent constitutional provisions under which this Court examines state action." *Allied Stores of Ohio v. Bowers*, 358 U.S. 522, 532 (1959) (Brennan, J., concurring).

It is well-settled that "[t]he Equal Protection Clause allows the States considerable leeway to enact legislation that may appear to affect similarly situated people differently." *Clements v. Fashing*, 457 U.S. 957, 962-963 (1982) (plurality opinion).

> [W]here individuals in the group affected by a law have distinguishing characteristics relevant to interests the State has the authority to implement, the courts have been very reluctant, as they should be in our federal system and with our respect for the separation of powers, to closely scrutinize legislative choices as to whether, how, and to what extent those interests should be pursued. In such cases, the Equal Protection Clause requires only a rational means to serve a legitimate end.

Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432, 441-442 (1985). *See also FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313-314 (1993) ("This standard of review is a paradigm of judicial restraint.")

Indeed, this Court has repeatedly observed that " . . . [The rational-basis standard] is true to the principle that the Fourteenth Amendment gives the federal courts no power

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[23] *Clements v. Fashing*, 457 U.S. 957, 963 (1982) (plurality opinion). *See also Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 457-458 (1988) ("Unless a statute provokes strict judicial scrutiny because it interferes with a fundamental right or discriminates against a suspect class, it will ordinarily survive an equal protection attack so long as the challenged classification is rationally related to a legitimate governmental purpose. [internal quotes and citations omitted]").

to impose upon the States their views of what constitutes wise economic or social policy." *Dallas v. Stanglin*, 490 U.S. 19, 27 (1989) (insert original, internal quotes omitted), *citing Dandridge v. Williams*, 397 U.S. 471, 485-486 (1970). Review under the rational-basis standard "is the most relaxed and tolerant form of judicial scrutiny under the Equal Protection Clause." *Dallas v. Stanglin*, 490 U.S. 19, 26 (1989).

> Although no precise formula has been developed, the Court has held that the Fourteenth Amendment permits the States a wide scope of discretion in enacting laws which affect some groups of citizens differently than others. The constitutional safeguard is offended only if the classification rests on grounds wholly irrelevant to the achievement of the State's objective. State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their laws result in some inequality. A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it.

McGowan v. Maryland, 366 U.S. 420, 425-426 (1961). *See also Dandridge v. Williams*, 397 U.S. 471, 485 (1970).

As Justice Stewart observed in his concurring opinion in *San Antonio School District v. Rodriguez*, 411 U.S. 1, 60 (1973), "[t]his doctrine is no more than a specific application of one of the first principles of constitutional adjudication – the basic presumption of constitutional validity of a duly enacted state or federal law. [citation omitted]" Thus, under the rational-basis standard, legislation is first presumed valid and then, shielded by that presumption, tested to determine if the classification it creates is rationally related to a legitimate state interest.[24]

In discussing this presumption in *Quill*, the Second Circuit stated: "[t]he general rule . . . is that state legislation

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[24] *See Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 440 (1985) ("The general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest. [citations omitted]").

carries a presumption of validity *if* the statutory classification is 'rationally related to a legitimate state interest.' [citation omitted]" *Quill*, 80 F.3d at 725 (emphasis added). This is incorrect. The existence of the presumption of validity is not conditioned upon a subsequent finding of rational relationship; rather, the presumption *precedes* application of the standard itself.[25] The Second Circuit's apparent failure to accord New York's statutes the presumption of validity to which they are entitled may provide at least some explanation why the Court utilized such a strict, skeptical, means-end analysis to review the challenged statutes.

While the Second Circuit did identify several important state interests implicated by New York's prohibition of assisted suicide, it went on to conclude that "[t]he New York statutes prohibiting assisted suicide, which are similar to the Washington statute, do not serve any of the state interests noted, *in view of the statutory and common law schemes allowing suicide through the withdrawal of life-sustaining treatment.*"[26] *Quill*, 80 F.3d at 730 (italics added).

This holding, like its misidentification of a similarly situated class, is based on the Second Circuit's failure to differentiate between the refusal of unwanted life-sustaining medical treatment and the acts of suicide and assisted suicide. Once this recurrent error is removed from the analysis, however, it immediately becomes clear that New York's prohibition of assisted suicide directly furthers, and thus is rationally

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[25] *See Heller v. Doe*, 509 U.S. 312, 319-320 (1993) ("For these reasons, a classification neither involving fundamental rights nor proceedings along suspect lines is accorded *a strong presumption of validity*. [emphasis added]"); *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 314-315 (1993) ("On rational-basis review, a classification in a statute such as the Cable Act comes to us bearing *a strong presumption of validity*, . . . and those attacking the rationality of the legislative classification have the burden 'to negate every conceivable basis which might support it,' . . . [citations omitted, emphasis added]").

[26] It is noteworthy that, at this point in its opinion, the Second Circuit abandoned the euphemism "hasten death" and, in its place, substituted the word "suicide."

related to, several important state interests. Those interests include, but are not limited to: (1) the protection and preservation of human life;[27] (2) the prevention of suicide;[28] (3) preventing the fraud, errors and abuse which would accompany acceptance of suicide and assisted suicide;[29] (4) maintaining the ethical integrity of the medical profession;[30] (5) protecting the poor and minorities from

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[27] *Cruzan*, 497 U.S. at 280.

[28] "Suicide is the eighth leading cause of death in the United States." New York State Task Force Report, *When Death is Sought – Assisted Suicide and Euthanasia in the Medical Context* (May 1994), at 9 (footnote omitted) (hereinafter "*When Death is Sought*"). "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." *Id.*, at 11. Furthermore, "[l]ike other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.*, at 13 (footnote omitted).

[29] *Cruzan*, 497 U.S. at 281 ("[E]ven where family members are present, [t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations. [citation and internal quotes omitted]"). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr. 59, 64 (1992) ("The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence."), and *Donaldson*, 2 Cal.App.4th at 1624 ("Third parties, even family members, do not always act to protect the person whose life will end.").

[30] *Cf. Middlesex Ethics Committee v. Garden State Bar Association*, 457 U.S. 423, 434 (1982) (important state interest in "maintaining and assuring the professional conduct of professional attorneys it licenses"). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1620, 4 Cal.Rptr.2d 59, 62 (1992) (recognizing state interest in maintaining the ethical integrity of the medical profession). In reaffirming its long-standing opposition to physician-assisted suicide, the American Medical Association has declared that physician-assisted suicide "threatens the very core of the medical profession's ethical integrity" and is "fundamentally inconsistent with the physician's professional role." American Medical Association, Council on Ethical and Judicial Affairs, *Code of Medical Ethics Reports*, Vol. V, No. 2

exploitation;[31] (6) protecting handicapped persons from societal indifference;[32] and (7) protecting innocent third parties.[33] Under the rational-basis standard, this should have been more than enough to establish the constitutionality of the challenged statutes.[34] However, in the case below, there was much more.

In 1985, then New York Governor Mario Cuomo convened the New York State Task Force on Life and the Law which he charged with responsibility to develop public policy recommendations on issues raised by medical advances. In May of 1994, the Task Force issued its 181 page report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, which has been characterized by one federal Court of Appeals as "[t]he most comprehensive study of our subject by a governmental body . . . " *Compassion in Dying v. State of Washington*, 49 F.3d 586, 591-592 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996). The Task Force unanimously recommended that New York's laws prohibiting assisted suicide and euthanasia should not be changed. *When Death is Sought*, at vii.

> After lengthy deliberations, the Task Force unanimously concluded that the dangers of such a dramatic change in public policy would far outweigh

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(July 1994), Report 59, *Physician-Assisted Suicide*, 269 and 274, respectively.

[31] *Quill*, 80 F.3d at 730, *citing Compassion in Dying v. State of Washington*, 49 F.3d 586, 592 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[32] *Quill*, 80 F.3d at 730, *citing Compassion in Dying v. State of Washington*, 49 F.3d 586, 592-593 (9th Cir. 1995), *superseded by* 79 F.3d 790 (9th Cir. 1996).

[33] *Application of President & Directors of Georgetown College, Inc.*, 118 U.S.App.D.C. 80, 331 F.2d 1000, 1008 (1964), *cert. denied*, 377 U.S. 978 (1964). *See also Bartling v. Superior Court*, 163 Cal.App.3d 186, 195 n.6, 209 Cal.Rptr. 220, 225 n.6 (1984).

[34] *Cf.* n.37, *infra*, and cases cited therein. *See also Heller v. Doe*, 509 U.S. 312, 320 (1993) ("A State, moreover, has no obligation to produce evidence to sustain the rationality of a statutory classification.").

> any possible benefits. In light of the pervasive failure of our health care system to treat pain and diagnose and treat depression, legalizing assisted suicide and euthanasia would be profoundly dangerous for many individuals who are ill and vulnerable. The risks would be most severe for those who are elderly, poor, socially disadvantaged, or without access to good medical care.[35]

While the Second Circuit was certainly aware of the Task Force Report (*see Quill*, 80 F.3d at 724, 730, and n.3), it plainly rejected it as an explanation of the "state of facts reasonably . . . conceived to justify [New York's prohibition of assisted suicide]." *McGowan v. Maryland*, 366 U.S. 420, 426 (1961). That was error. It is difficult to imagine a more comprehensive explanation for a legislative decision. It is also difficult to imagine what is required under the rational-basis standard if the Task Force Report is insufficient.[36] In summary, had the Second Circuit applied the rational-basis standard of review in accordance with the precedents of this Court, New York's prohibition of assisted suicide clearly would have passed constitutional muster.[37]

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[35] *When Death is Sought*, at ix. *See also Id.*, at vii-viii. Since publication of the Task Force Report, the New York Legislature has taken no action to amend or repeal New York's prohibition of assisted suicide, N.Y. Penal Code, §§ 125.15(3) and 120.30.

[36] *Cf. Gregory v. Ashcroft*, 501 U.S. 452, 473 (1991) (finding Missouri mandatory retirement age of 70 for most state judges to be rationally related to a legitimate state interest, but noting that it "is founded on a generalization" which "may not be true at all."). *See also Heller v. Doe*, 509 U.S. 312, 321 (1993) ("Finally, courts are compelled under rational-basis review to accept a legislature's generalizations even when there is an imperfect fit between means and ends.").

[37] *Cf. McGowan v. Maryland*, 366 U.S. 420, 426 (1961); *Dandridge v. Williams*, 397 U.S. 471, 486 (1970); *San Antonio School District v. Rodriguez*, 411 U.S. 1, 44-55 (1973); *Washington v. Davis*, 426 U.S. 229, 245 (1976); *Massachusetts Board of Retirement v. Murgia*, 427 U.S. 307, 314 (1976); *Vance v. Bradley*, 440 U.S. 93, 98-102 (1979); *Bowen v. Owens*, 476 U.S. 340, 348-350 (1986); *Kadrmas v. Dickinson Public Schools*, 487 U.S. 450, 457-465 (1988); *Dallas v. Stanglin*, 490 U.S. 19, 27 (1989); *Gregory v. Ashcroft*, 501 U.S. 452, 470-473 (1991).

III. THE SECOND CIRCUIT'S CONSTITUTIONAL ANALYSIS WAS FUNDAMENTALLY FLAWED BY THE IMPROPER INSERTION OF QUALITY-OF-LIFE CONSIDERATIONS

The Second Circuit's application of the rational-basis standard was further flawed by the improper insertion of quality-of-life considerations which it used to discount the State's important interests in the protection and preservation of human life. *Quill*, 80 F.3d at 729-730. In this regard, the Second Circuit stated: "[w]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes." *Quill*, 80 F.3d at 729-730 (citation omitted). The Second Circuit's characterization of the life at stake as one "that is all but ended" is based on the mistaken notion that the life at stake is of little, if any, value. Moreover, it is at this critical time, when life is "all but ended," that the person whose life is at stake is in greatest need of the State's protection. Indeed, as the Court observed in *Cruzan*, "even where family members are present, [t]here will, of course, be some unfortunate situations in which family members will not act to protect a patient. A State is entitled to guard against potential abuses in such situations."[38]

Such improper quality-of-life considerations are also directly contrary to this Court's holding in *Cruzan* that "a

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[38] *Cruzan*, 497 U.S. at 281 (citation and internal quotes omitted). *See also Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr. 59, 64 (1992) ("The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence."), and *Donaldson*, 2 Cal.App.4th at 1624 ("Third parties, even family members, do not always act to protect the person whose life will end."). Of course, individual interests are not afforded any less protection simply because the government, rather than the individual, is defending them. *Cruzan*, 497 U.S. at 282 n.10.

State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Cruzan*, 497 U.S. at 282. The dangers inherent in using such quality-of-life considerations are well-recognized.[39] "Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives." *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. banc 1988), *aff'd sub nom. Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). An analysis such as that engaged in by the Second Circuit also disregards the irrefutable principle that all lives, from beginning to end and irrespective of physical or mental condition, are under the full protection of the law.

> The life of those to whom life has become a burden – of those who are hopelessly diseased or fatally wounded – nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Blackburn v. State, 23 Ohio St. 146, 163 (1872).

In discounting the State's important interests in the protection and preservation of human life, the Second Circuit also relied upon broad generalities from the Court's opinion in *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992), on the nature of the liberty protected by the Fourteenth Amendment. *Quill*, 80 F.3d at 730. That reliance was particularly surprising since *Casey* itself reaffirms the States' "legitimate interests from the outset of the pregnancy in protecting the

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[39] *See, e.g., Mack v. Mack*, 618 A.2d 744, 760 (Md. 1993) ("As a logical progression from that precedent [patients in a persistent vegetative state], cases eventually would be presented submitting that the best interest of the most severely retarded and feebleminded, who require extended care, who have practically no cognition, and who are too disabled to feed themselves, would be to have sustenance withheld. [citation omitted]").

health of the woman and the life of the fetus that may become a child." *Casey*, 505 U.S. at 846. Nevertheless, the Second Circuit relied on *Casey* when it posed the following question:

> What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life," *Planned Parenthood v. Casey*, 505 U.S. 833, 851, 112 S.Ct. 2791, 2807, 120 L.Ed.2d 674 (1992), when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

Quill, 80 F.3d at 730 (insert original).

There are at least two fundamental flaws in the Second Circuit's reliance on *Casey* for this proposition. First, "[i]t is not the province of [the courts] . . . to create substantive constitutional rights in the name of guaranteeing equal protection of the laws." *San Antonio School District v. Rodriguez*, 411 U.S. 1, 33 (1973) (insert added). That, however, was precisely what the Second Circuit did in this case. Within the broad generalities on the nature of liberty contained in *Casey*, the Second Circuit created a new right "to have drugs prescribed to end life during the final stages of a terminal illness." *Quill*, 80 F.3d at 730. The creation of this new right – substantive due process in disguise – was error.

> Unlike other provisions of the Constitution, the Equal Protection Clause confers no substantive rights and creates no substantive liberties. The function of the Equal Protection Clause, rather, is simply to measure the validity of *classifications* created by state laws.

San Antonio School District v. Rodriguez, 411 U.S. 1, 59 (1973) (Stewart, J., concurring) (italics original, footnote omitted). Second, this is precisely the sort of "unlimited right to do with one's body as one pleases" which this Court has consistently and soundly rejected. *See Roe v. Wade*, 410 U.S. 113, 154 (1973); *Bowers v. Hardwick*, 478 U.S. 186, 191 (1986); and *Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68

(1973), *citing*, *inter alia*, constitutionally unchallenged laws against suicide.

Finally, in *Quill*, the Second Circuit suggested that New York could achieve its objective of avoiding " 'psychological pressure' " on the elderly and infirm to choose death by "establish[ing] rules and procedures to assure that all choices [to commit assisted suicide] are free of such pressures." *Quill*, 80 F.3d at 730 (inserts added). With respect to the definition of "terminal illness," the Second Circuit suggested that "New York may define that stage of illness with greater particularity, require the opinion of more than one physician or impose any other obligation upon patients and physicians who collaborate in hastening death." *Quill*, 80 F.3d at 731 (footnote omitted). In the footnote which accompanies the above-quoted text, the Second Circuit went on to suggest numerous other ways in which the State of New York could achieve its objectives but still allow assisted suicide. *Quill*, 80 F.3d at 731 n.4.

This same argument – that the State may be able to achieve its objectives through alternative means – was rejected by the Court in *Dallas v. Stanglin* and, as in that case, "misapprehend[s] the nature of rational-basis scrutiny, which is the most relaxed and tolerant form of judicial scrutiny under the Equal Protection Clause." *Dallas v. Stanglin*, 490 U.S. 19, 26-27 (1989). The fact that a State may, if it chooses, seek to achieve its legitimate objectives through other means does not, in any way, establish that the means actually selected are either irrational or arbitrary.[40]

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[40] *See San Antonio School District v. Rodriguez*, 411 U.S. 1, 51 (1973) (Texas system of financing public education does not fail, under rational basis standard, simply because other "less drastic" methods of satisfying the State's interest might be conceived); *Vance v. Bradley*, 440 U.S. 93, 102-103 n.20 (1979) ("irrelevant to equal protection analysis [under rational-basis standard] . . . that other alternatives that might achieve approximately the same results, . . . [insert added]"); *Heller v. Doe*, 509 U.S. 312, 329-330 (1993) (alternative methods of achieving state objective "irrelevant in rational-basis review.").

Moreover, "[t]he very complexity of the problems. . . suggests that there will be more than one constitutionally permissible method of solving them, and that, within the limits of rationality, the legislature's efforts to tackle the problems should be entitled to respect." *San Antonio School District v. Rodriguez*, 411 U.S. 1, 42 (1973) (internal quotes and citation omitted). Simply stated, it is not the business of this Court to attempt to resolve the myriad of complex ethical, moral, social, religious, medical, and philosophical problems presented by the issue of physician-assisted suicide.[41] In this regard, the words of the Court in *San Antonio School District v. Rodriguez*, 411 U.S. at 43, have equal application here:

> In such circumstances, the judiciary is well advised to refrain from imposing on the States inflexible constitutional restraints that could circumscribe or handicap the continued research and experimentation so vital to finding even partial solutions to educational problems and to keeping abreast of ever-changing conditions.

IV. THE DECISION BELOW SHOULD BE REVERSED IN ORDER TO PRESERVE THE ESSENTIAL ROLE OF THE STATES IN OUR FEDERAL SYSTEM OF GOVERNMENT AND THE POWER OF THE PEOPLE TO DIRECTLY GOVERN THEIR OWN AFFAIRS

With the ever-increasing power of medical science to prolong life, even in the face of what would otherwise be terminal illness, the States have had to strike a balance between the rights of the individual and "the demands of

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[41] *Cf. Dandridge v. Williams*, 397 U.S. 471, 487 (1970) ("the intractable economic, social, and even philosophical problems presented by public welfare assistance programs are not the business of this Court."). *See also* Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1 (1996) (surveying legislative activity in the United States regarding physician-assisted suicide and discussing why successful regulation would be impossible in both principle and practice).

organized society." *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting). That balance is grounded in the States' recognition of their responsibility to protect both individual liberty and, at the same time, the lives of the people, both those who wish to die and those who wish to live no matter what their circumstances. In striking that balance, the States have drawn a line between an individual's right to refuse unwanted medical treatment and killing oneself, with or without the assistance of another. That balance, now a national consensus, is represented by statutes in a majority of States which both recognize an individual's right to refuse unwanted medical treatment and, at the same time, reject any affirmative act to end life. *See* ns. 14-16, *supra*. Whether that balance should be abandoned and the line redrawn to permit an individual to commit suicide without state interference, and then redrawn yet again to permit assisted suicide, is a matter appropriately left for the people to decide, through their duly elected representatives or by initiative ballot.[42] The principles of federalism embodied in our Constitution require no less.

As the States grapple with the difficult questions presented by the ever-increasing ability of medical technology to prolong life, the corresponding need to allow the States to serve as laboratories for change becomes paramount.[43] Indeed, as this Court has recognized, "[t]he science of government . . . is the science of experiment, . . . " *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985) (citation and internal quotes omitted). While "[t]his Court has the power to prevent experiment" (*New State Ice*

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[42] *See People v. Kevorkian*, 447 Mich. 436, 481-482, 527 N.W.2d 714, 733 (1994), *cert. denied*, 115 S.Ct. 1795 (1995), and *Donaldson v. Lungren*, 2 Cal.App.4th 1614, 1623, 4 Cal.Rptr.2d 59, 64 (1992).

[43] *Cf. San Antonio School District v. Rodriguez*, 411 U.S. 1, 50 (1973) ("No area of social concern stands to profit more from a multiplicity of viewpoints and from a diversity of approaches than does public education."). *See also Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991) ("federalist structure of joint sovereigns preserves to the people numerous advantages" including "allow[ing] for more innovation and experimentation in government; . . . [insert added]").

Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting)), it should refrain from doing so here.[44]

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.

Id.

A decision affirming the Second Circuit's opinion in *Quill* will effectively extinguish the power of the States to continue to serve as laboratories for change on an issue that

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[44] Just such an experiment may soon take place in the State of Oregon where, in November of 1994, the people voted to accept Measure 16, a ballot initiative allowing a terminally ill, mentally competent adult to obtain a physician's prescription for the purpose of ending his/her life. While Measure 16 has been declared unconstitutional as violative of the Equal Protection Clause, and its operation permanently enjoined by the district court (*Lee v. State of Oregon*, 891 F.Supp. 1421, 1438-1439 (D.Or. 1995)), that decision is presently on appeal to the United States Court of Appeals for the Ninth Circuit, which recently heard oral argument in the case. Should Measure 16 ever take effect, the eyes of the Nation will turn to Oregon to see whether a State can safely walk down a road which history has taught us is fraught with danger. *See When Death is Sought*, at 133-134 (reporting abuses, including nonvoluntary euthanasia, which have occurred in the Netherlands where, since 1984, guidelines have tacitly allowed the practice and concluding that "If euthanasia were practiced in a comparable percentage of cases in the United States, voluntary euthanasia would account for about 36,000 deaths each year, and euthanasia without the patient's consent would occur in an additional 16,000 deaths.") *See also Rodriguez v. Attorney General of Canada, et al.*, 3 S.C.R. 519, 603 (1993) (decision upholding Canada's ban on assisted suicide, noting: "Critics of the Dutch approach point to evidence suggesting that involuntary active euthanasia (which is not permitted by the guidelines) is being practised to an increasing degree. This worrisome trend supports the view that a relaxation of the absolute prohibition takes us down 'the slippery slope'. [insert original]") (Sopinka, J., writing for the majority).

arguably will affect more lives than any other issue the States will face in the foreseeable future. It will also "invite[] an unelected federal judiciary to make decisions about which state policies it favors and which ones it dislikes." *Garcia v. San Antonio Metro.*, 469 U.S. 528, 546 (1985). At the same time, it will "relegate the States to precisely the trivial role that opponents of the Constitution feared they would occupy."[45] *Garcia, supra*, 469 U.S. at 575 (Powell, J., dissenting) (footnote omitted). In the words of Circuit Judge Kleinfeld, "[t]he Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary." *Compassion in Dying v. State of Washington*, 79 F.3d 790, 858 (9th Cir. 1996) (Kleinfeld, C.J., dissenting).

CONCLUSION

For all the foregoing reasons, the judgment of the United States Court of Appeals for the Second Circuit in No. 95-1858 should be reversed.

Respectfully submitted,

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[45] "If the several States in the Union are to become one entire Nation, under one Legislature, the Powers of which shall extend to every Subject of Legislation, and its Laws be supreme & controul the whole, the Idea of Sovereignty in these States must be lost." Samuel Adams, Letter to Richard Henry Lee, 3 Dec. 1787, in *The Writings of Samuel Adams* 4:324 (Harry A. Cushing ed. 1968).

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Nos. 95-1858, 96-110

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In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

and

STATE OF WASHINGTON, CHRISTINE O. GREGIORE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF *AMICI CURIAE* OF THE NATIONAL ASSOCIATION OF PROLIFE NURSES, NATIONAL ASSOCIATION OF DIRECTORS OF NURSING ADMINISTRATION IN LONG TERM CARE, PHILIPPINE NURSES ASSOCIATION OF AMERICA, SCHOLL INSTITUTE OF BIOETHICS, CALIFORNIA NURSES FOR ETHICAL STANDARDS IN SUPPORT OF PETITIONERS

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38 pp

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

INTEREST OF *AMICI CURIAE*: Damage to the liberty and property rights of nurses 1

SUMMARY OF ARGUMENT 3

ARGUMENT: The Courts of Appeal granted an entitlement to assisted suicide which inculpates nurses, thereby denying liberty and property rights of nurses to practice a profession undamaged by assistance in suicide 3

1. Legal assisted suicide would inculpate all nurses in assisted suicide, denying nurses the liberty and property interests in their profession 4

   a. Legal assisted suicide would inculpate nurse practitioners as prescribers of drugs used in suicide 6

   b. Nurses other than nurse practitioners would be affected by legal assisted suicide 8

      (1) The practice of every nurse would be changed by legal assisted suicide (which seeks to solve a nonexistent problem) 8

      (2) Hospice and home health nursing practice would be changed under legal assisted suicide 11

      (3) Hospital and long term care nursing practice would be changed under legal assisted suicide 13

   c. Anticipation of legal assisted suicide in one state has caused its nurses to accept involvement 15

TABLE OF CONTENTS – Continued

Page

2. Legal assisted suicide would harm the ethics and law of nursing; the threat already has done harm..... 16

   a. Legal assisted suicide would erode the ethics and law of nursing..... 16

   b. The national standard of ethics for nurses is that nurses do not assist patients to kill themselves; but threat of legal assisted suicide has caused erosion of that standard..... 23

3. Legal assisted suicide would inculpate nurses in assisting suicide, damaging the profession in the eyes of the public..... 27

   a. Under legal assisted suicide, some nurses *would* assist in patient killing..... 27

   b. If legal, future killing would be delegated to nurses..... 28

   c. Allowing nurses to legally assist suicide would result in deterioration of the public's trust in their profession..... 29

CONCLUSION: The decisions of the Courts of Appeal grant an entitlement to assisted suicide, denying to nurses their liberty and property rights in their profession..... 30

APPENDIX 1a

TABLE OF AUTHORITIES

Page

CASES

Airedale NHS Trust (Respondents) v. *Bland* (Acting by his guardian *ad litem*) (Appellant) London: House of Lords, 1993..... 6

Compassion in Dying v. *State of Washington*, 79 F.3d 790 (9th Cir.1996)..... 2

Greene v. *McElroy*, 360 U.S. 474 (1959) 5

In re Jobes, 529 A.2d 434 (N.J. 1987) 6

Quill v. *Vacco*, 80 F.3d 716 (2d Cir.1996) 23

Rust v. *Sullivan*, 500 U.S. 173 (1991)..... 10

Satz v. *Perlmutter*, 362 So.2d 160 (Fla.1980) 5, 24

Superintendent of Belchertown v. *Saikewicz*, 370 N.E.2d 417 (Mass.1977).....5, 24

Truax v. *Raich*, 239 U.S. 33 (1915)..... 5

STATUTES

42 U.S.C. Sec. 1395cc(a)(1) *et seq*..... 10

Oregon Ballot Measure 16, Section 3.14..... 13

Oregon Ballot Measure 16, Section 4.01(4) 8

Oregon Ballot Measure 16, Section 6..... 14

Or. Rev. Stat. 410.610 *et seq*. 19

Or. Rev. Stat. 441.630 *et seq*. 19

Or. Rev. Stat. 678.111(b)..... 18

TABLE OF AUTHORITIES – Continued

Page

Or. Rev. Stat. 678.111(f) 18

Or. Rev. Stat. 678.385 6

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American Nurses Association, *Code for Nurses with Interpretive Statements* (1986) 25

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Exodus Chapter 20, Verse 13 26

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Page

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UCSF suspends nurses who delayed reporting incident, NURSEweek, First April 1995, 3, 20 26

INTEREST OF *AMICI CURIAE*:

The decisions of the Courts of Appeal damage the liberty and property rights of nurses.

Letters of the parties consenting to file this brief *amici curiae* have been filed with the Court. Descriptions of each group filing this *amici* brief are set forth in the Appendix.

By striking state laws criminalizing assisted suicide, the decisions of the Courts of Appeal, if affirmed, would make assisted suicide legal. The *amici curiae* will be uniquely and directly affected by the Court's decision in this case. To demonstrate their unique interest, *amici* will present evidence that nurses would be 1) involved, and 2) detrimentally affected, if assisted suicide were made legal.

The decisions of the Courts of Appeal on review grant an entitlement not only to "physician-assisted suicide" but also (a fact unknown to many) to "nurse-assisted suicide." The practitioner most likely to be with the patient as he dies, is his nurse. A large difference exists between the professions of nursing and other professionals in illness care, regarding the care of terminal patients. The patients who are the subject of assisted suicide almost always require nursing care, not always medical care. At the very time when medicine may have little to offer the patient, the nurse can give comfort, concern, and care. The interest of nurses in what happens to their dying patients is unique, even among other professionals.

The nurses' interest differs from other professionals in another way: nurses are almost always employees. They will not have the luxury that other professions might have, abstractly and coolly to deliberate on whether to assist a patient in suicide. Nurses rarely can choose their patients; they are assigned to them. Because of their societal and employment status, nurses would be vulnerable to pressures to assist in suicide against their professional or ethical judgment. They are often in the unenviable position of being responsible for executing decisions in which they have no voice. The nursing coat of arms in some instances might well read: "Responsibility without Authority."

The effect of inculpating nurses in the self-killing of their patients will not be addressed by any other *amici* or Party. The effect is this: If assisted suicide is made legal, nurses will be asked to assist suicide. All nurses care for patients who die, and some of their patients might die by prescription. That nursing care would be nurse assistance in suicide, because the definition of "assist" cannot be narrowly limited only to providing medication. Those nurses and thus the whole profession would be inculpated in nurse-assisted suicide. Further, Nurse Practitioners (NPs) in several states now legally prescribe the medications that would be used to cause death in patients.

The Nurses' concern for their *patients* who would be harmed, will be addressed by other *amici*. Nurses add that the harm done to the profession of nurses, the largest group of practitioners who care for patients, would affect not only current patients but all who would need nursing care in the future.

All nurses would be involved intimately in the death of their patients who might self-kill. The decision of one of the Courts of Appeal contemplates this, together with an assumption that at some future time euthanasia may be delegated:

> "We recognize that in some instances, the patient may be unable to self-administer the drugs [for suicide] and that administration by the physician, **or a person acting under his direction or control** may be the only way the patient may be able to receive them." [Emphasis and material in brackets added]. *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 at 831 (9th Cir.1996).

The inevitable inculpation of nurses in legal assisted suicide would erode the personal and professional ethics of nurses, expose them to criminal and civil sanctions, and destroy the confidence of the public in the profession. Thus the nurses' rights to liberty and property in the practice of their profession would be violated.

SUMMARY OF ARGUMENT

The decisions of the Courts of Appeal grant the entitlement to suicide with assistance and approval and thereby deny liberty and property rights of nurses in their profession, damaged irrevocably by nurse assistance in the deliberate deaths of patients. Nurses would be 1) inculpated, and 2) harmed, by legal assisted suicide:

1. Under legal assisted suicide, nurse practitioners and all other nurses would be inculpated in nurse-assisted suicide. One association of nurses already has advised its members that nurses would be involved in assisting suicide if it were legal.
2. Legal assisted suicide would harm irrevocably the ethical and legal basis of the nursing profession; current ethical standards of nurses would be eroded; and the public's perception of the profession would deteriorate, all causing damage to the liberty and property rights of nurses in practicing their profession.

ARGUMENT

To commit suicide with assistance and approval is not a right but an entitlement. Making assisted suicide legal does not merely allow the ability to do an act by one person, but confers the power to involve another person in the act.

Nurses leave to other *amici* the elaboration of the certain fact that the vast majority of people who seek suicide are psychologically impaired. Even terminal patients in pain do not seek death (and *amici* assert this pain can be relieved, under current standards of care). E.J. Emanuel, *et al, Euthanasia and physician-assisted suicide: attitudes and experiences of oncology patients, oncologists, and the public*, 347 Lancet 1805 (1996).

Terminally ill patients who seek to die are almost invariably depressed and ambivalent about dying, and those patients can be helped with medication. If encouraged, such ambivalent patients will choose to live. For the rare patient who is terminal, competent, non-depressed and seeking suicide with help (and even that patient is likely ambivalent about dying):

Before these Courts of Appeal decisions, prescriptions have been written with knowledge that their purpose was suicide. Though that information has been acknowledged, no prescribers have ever been convicted of assisting suicide. T.H. Stone & W.J. Winslade, *Physician-assisted suicide and euthanasia in the United States*, 16 J. Leg. Med. at 492 (1995).

The aim of making assisted suicide legal, then can be seen. It is not merely to allow a prescription for the few competent, terminal, non-depressed patients who would commit suicide with such drugs. Instead, it provides a prescription *with approval of its purpose*. This prescription would be visible evidence of approval of the act from the doctor or nurse practitioner. Legal assisted suicide confers the entitlement to suicide with approval, by inculpating the professions. The intent is to give to the act the imprimatur and approval of the law, and of the professional.

The tacit tolerance of assisted suicide already creates the perception that some special cases exist that warrant assisted suicide. This tolerance would become explicit if legal. The nurse would be forced to act either in compliance with her conscience (to safeguard her patient, profession, and opinion of herself), or to act in compliance with what would then be the law. She would have to be silent or even assist suicide.

1. Legal assisted suicide would inculpate all nurses in assisted suicide, denying nurses the liberty and property interests in their profession.

The relationship of nurses to their patients has been called a social contract with the public. That is, the public/patient knows in general what a nurse is, and what she is expected to do. People who are currently in the profession entered that work with the knowledge of, and expectation of, what their work would be. They have a property interest in their occupation; and they have a liberty interest in being able to practice the profession as it exists without arbitrary government interference. Both interests have been found to rise to the level of fundamental rights, deserving Constitutional protection.

> " . . . [T]he right to work for a living in the common occupations of the community is of the very essence of the personal freedom and opportunity that it was the purpose of the Amendment to secure."

Truax v. *Raich*, 239 U.S. at 41 (1915); and

> "[T]he right to hold specific private employment **and to follow a chosen profession** free from unreasonable governmental interference comes within the 'liberty' and 'property' concepts of the Fifth Amendment."

Greene v. *McElroy*, 360 U.S. at 492 (1959) [Emphasis and material in brackets added].

The liberty and property interests asserted here are not merely in a specific job, though specific employment also may be endangered for the nurse who will not participate. The nurse who will not participate in assisting suicide cannot merely go to another nursing job that is unaffected by legal assisted suicide. Any and all nurses would find their profession damaged by the inculpation of nurses in assisted suicide. All jobs, all nurses, would be tainted.

The practice of nursing does evolve and change; but the underlying values expressed in the ethics of nursing, and enforced in the minimum of the law, have not changed in thousands of years. The *amici* assert that it has not ever been the legitimate work of their profession to assist patients to kill themselves. Legal assisted suicide would make those acts part of the work of nurses.

Courts have always considered the effect of their decisions on all the people involved in a case. Under these decisions, the nurses are immediately and intimately and detrimentally involved. In particular, the impact of their decisions on the integrity of the professions has been of major concern to courts. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980).

Other courts have expressed concern for nurses asked to assist in causing death in their patients (in the case quoted below, by denying nursing care).

> I find it difficult to understand how we can order nursing professionals with an abiding respect for their patients to cease to furnish the most basic of human needs to a patient in their care. [Such an order] may impinge on the privacy rights of those nursing professionals.

In re Jobes, 529 A.2d at 464 (N.J. 1987) (O'Hern, J., dissenting). [Material in brackets added].

Another court worried about the ethics of nurses asked to assist in deliberately dehydrating to death a comatose patient:

> . . . for almost all concerned the adoption of the proposed course will be a merciful relief, [but] this will not be so for the nursing staff, who will be called on to act in a way which must be contrary to all their instincts, training and conditions. They will encounter the ethical problems, not in a court or in a lecture room, but face to face.

Lord Mistill, House of Lords. *Airedale NHS Trust (Respondents)* v. *Bland* (Acting by his guardian *ad litem*) (Appellant) London: House of Lords, 1993 [Material in brackets added].

a. Legal assisted suicide would inculpate nurse practitioners as prescribers of drugs used in suicide.

If assisted suicide were legal, nurse practitioners in many states would be affected in exactly the same way as physicians. They would be seen as practitioners who could prescribe death instead of promoting life. In some states nurse practitioners potentially can prescribe all the drugs that patients seeking to suicide most likely would be prescribed to kill them. Drugs that might be prescribed are used at present for pain, sleep, anxiety, or depression, all of which categories some nurse practitioners legally can prescribe now. See, for example, Or. Rev. Stat. 678.385.

Patients who could legally obtain drugs for the purpose of suicide from physicians could get a prescription for the same or similar drug from a nurse practitioner. This is so, even if the NP technically could not prescribe for the *purpose* of suicide. If prescriptions from the physician for the purpose

of assisted suicide were legal, patients would be encouraged (and perhaps even more likely) to ask for the same drugs from their nurse practitioner. Patients who formerly might not have sought a prescription for suicide might be encouraged to do so if it were legal. The legality of the prescription would remove the stigma from suicide or at least spread it onto the prescriber.

Nurse practitioners in the future likely would be included as "prescribers" if assisting suicide were legal. The equal protection clause of the Fourteenth Amendment to the Constitution would prohibit the exclusion of Nurse Practitioners from prescribing drugs for self-killing. The limitation of such prescriptions to physicians would discriminate without rational basis, since nurse practitioners too could prescribe the drugs most likely to be used to kill the patient.

To assert that the prescription of killing drugs could be limited to physicians because they are better qualified to judge the mental status of the patient, has no factual basis. Comparison of the curricula of their respective educational programs would demonstrate that nurse practitioners (especially those working in mental health) are even more likely than doctors to have been educated in psychosocial components of care. Thus nurse practitioners are at least as able as physicians to assess patients for their competency in making a request to die. Nurse practitioners would be inculpated in legal nurse-assisted suicide as prescribers. Their exclusion will not meet the rational basis standard of Amendment Fourteen of the Constitution.

Nurse practitioners unwilling to assist the patient in suicide likely would be required to transfer medical records to the next practitioner chosen to assist suicide, just as physicians would be. This participation would be required, regardless of the religious or moral or professional objections of the nurse to inculpation in the self-killing. The nurse's objection that suicide was inappropriate for this patient, based on her assessment of the patient, would be no bar to enforcing such

transfer of records. An example of such requirement to transfer patient records in a law with "safeguards" as recommended by the decisions of the Courts of Appeal, is Oregon Ballot Measure 16, Section 4.01(4).

b. Nurses other than nurse practitioners would be affected by legal assisted suicide.

(1) The practice of every nurse would be changed by legal assisted suicide (which seeks to solve a nonexistent problem).

Legal assisted suicide would affect all nursing practice; most nurses care for terminal patients on a daily basis. Some of those patients (those who are depressed and ambivalent) might seek suicide with assistance. Participating in assisted suicide would become part of the practice of nursing. The consequences of legal assisted suicide noted below support that conclusion, and it is admitted by the position of the Oregon Nurses Association (ONA) discussed more fully below. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

If assisted suicide were legal, according to the ONA paper discussed below, even the nurse who is morally opposed to assisted suicide would be required to inform the patient of his right to referral to a physician (or nurse practitioner) who would prescribe a lethal dose. For some nurses, supplying this information would be assisting the patient's suicide. They would assist, as surely as did German nurses under National Socialism assist euthanasia. Those German nurses identified some children as retarded, knowing the result of the diagnosis would be death.

From the research done on attitudes and behavior of patients who are terminally ill, it is evident that the Courts of Appeal have written law to solve a problem that does not exist. Data cited above (Emanuel) show that patients who seek suicide are depressed and at least ambivalent about their wish to die. Practitioners are notoriously bad at diagnosing

and treating depression[1] (a reason to educate practitioners, not a reason to assist depressed patients to suicide). The data also show that competent terminal patients, even those (unnecessarily) in pain, are very unlikely to seek suicide.

According to research studies, a large majority of patients want heroic efforts made if they die. They may overestimate the success rate of heroic efforts, but patients who are very seriously ill, even those that might be classed as "terminal," want to live. R.S. Phillips *et al, Choices of seriously ill patients about cardiopulmonary resuscitation: correlates and outcomes*, 100 Am. J. Med. 128 (1996).

At present, the nurse's duty toward a depressed patient dying in pain is to alleviate the pain and treat the depression, both remediable conditions. If assisted suicide were made legal, the nurse's practice would be changed, perhaps to assist the patient to suicide in order to relieve depression and pain. Effective (non-lethal) treatment is available right now for depression and pain. *Amici* know it is not necessary to end the patient, to end his pain.

The Courts of Appeal have confused withdrawing treatment that patients do not want, with suicide, assisted suicide, and euthanasia. Researchers too have confused refusing treatment with suicide, resulting in studies that seem to indicate that intensive care nurses already assist suicide or euthanize patients. D.A. Asch, *The role of critical care nurses in euthanasia and assisted suicide*, 334 N. Eng. J. Med. 1374 (1996). In reality, only treatment that the patient rejects is removed. Often the treatment rejected would not have prolonged the patient's life in any event. The public (including jurists and researchers) overestimate also the success rate of medicine and nursing in prolonging life with heroic efforts.

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[1] Purported safeguards in legislation such as those in Oregon's Measure 16, ask the practitioner to refer the patient who may be depressed for counseling. But many practitioners cannot recognize the diagnosis in the first place, so they cannot refer. New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994) p. 127.

Though it may be blurry to the Courts of Appeal, the line is very clear and bright between withdrawing treatment which would not prolong life, and actively causing death. Nurses are adamant that care that is not useful, and is not wanted, be ended. The nurse is very often the patient's greatest advocate in such situations. She will take whatever measures are needed to see that the patient's wishes are honored. These measures may include conversations (even confrontations) with doctors, ethics committees and employers. But for the nurse, it is a thousand leagues distance from honoring her patient's wish to stop treatment – to being her patient's agent of death.

Under legal assisted suicide a nurse would encounter a family pressuring the terminal patient to die (subtly or not, and done for the patient's benefit or not). Currently, this behavior might rise to the level of neglect or abuse of an elderly or dependent patient, and the nurse's obligation is to report it. Under legal assisted suicide, the nurse's practice would be changed (perhaps to refer the patient and family to a practitioner who would prescribe a lethal dose).

Under legal assisted suicide, federal law might require nurses to inform the patient who is even possibly "terminal," of his right under state law to assisted suicide. The Patient Self-Determination Act 42 U.S.C. Sec.1395cc(a)(1) *et seq.* requires recipients of Medicare funds (hospitals, skilled nursing facilities, home health agencies, and hospice programs) to provide information to each patient concerning

> "an individual's rights under State law . . . to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives."

Even government employers may require practitioners to give information preferred by the employer's policy. *Rust* v. *Sullivan*, 500 U.S. 173 (1991). Private employers surely would be able to dictate information to be given. For employers of nurses such as managed care companies or their contractors (virtually all employers of nurses are included in the latter category), the patient's suicide or euthanasia might

be a very cost effective procedure. If the procedures were legal, nurses would be under pressure to assist suicide and euthanize. Nurses might be expected to suggest such "alternatives" to expensive care.

Nurses could be directed by their employers to tell patients that help in killing themselves is available, or be at risk of losing their jobs. Some nurses from strong religious and ethnic tradition, and other nurses who also place primary value on the life of the patient, would be especially at risk. If legal, such nurses who work on oncology and AIDS units, in long term care, hospice, and home health would find their job opportunities limited if they declined to participate in assisted suicide.

Nurses could be forced to choose between job and conscience in a time of shrinking job opportunities in nursing. Most nurses work as "at will" employees, vulnerable to covert and overt pressures to conform to employer goals. Nurses are career professionals, whose jobs usually provide the main source of income in their families. Many could not afford the luxury of maintaining their ethical standards at the cost of losing their livelihood.

(2) Hospice and home health nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some hospice or home health nurse would visit her patient to find he had obtained a massive overdose of drugs. (If legal, it would be considered not an overdose but a "correct" dose to kill himself.) Before legal assisted suicide, the nurse would have assumed her duty was to help the patient live. After legal assisted suicide, the nurse's duty could conceivably be to counsel how best to take the drugs to assure death.

Under legal assisted suicide, some nurse who made a visit to check on her patient would find the patient had already ingested the prescribed overdose. (If legal, the dose would be called the "correct" dose – to kill the patient.) Currently, the nurse's duty is to call 911 and resuscitate.

Under legal assisted suicide, the nurse's duty might be to remain passively with the patient/family until the death. The ONA paper [cited below] suggests that if no other nurse were available, legal assisted suicide would create a duty to stay passively with the patient until death, regardless of the nurse's strong intent *not* to assist suicide.

The nurse whose patient would die by legal prescription would be inculpated in the death, because such a death is not so swift or sure or painless as might be assumed.[2] The patient may not die immediately or even within several hours or days. In addition to taking the prescription, proponents of suicide advise placing a plastic bag over the patient's head to assure asphyxiation if the patient awakens. This course of events is said to be not uncommon.

The ONA paper below suggests that even the nurse who did not wish to assist the patient in suicide, still would have to assume the patient's "end of life care" if assisted suicide were legal. If she were unable to transfer the suiciding patient to another nurse, she would have no choice but to participate.

Under legal assisted suicide, the nurse's duty might be changed horribly, perhaps extending to placing the plastic bag over the patient's head if the patient were unable to do so.

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[2] Prescribers for legal assisted suicide would not be competent to prescribe for a totally new purpose – to kill. To illustrate the problem: Excellent pain control measures are available, but many physicians and nurse practitioners are still unable to prescribe appropriate pain control for terminal patients. (This is not an excuse to kill the patient to relieve the pain, but a reason for more education of prescribers about the near 100% effective relief available.) Considering that current failing, it would be long before prescribers were good at killing. There is no scientific basis for this practice and doctors and nurse practitioners have had no experience in doing it. A new era of research would result if assisted suicide were legal. Such investigation of how to kill people yielded the Guillotine in the 18th Century, and the gas chamber in the 20th. It might well be asked what rough science slouches toward the 21st Century to be unearthed.

Eyewitnesses assert that it is sometimes necessary to hold the suiciding person's hands as he smothers, to keep him from forcefully removing the bag. The nurse's duty could extend to doing that.

If assisted suicide were legal, a hospice or home health nurse would find a suiciding patient alone and with no plastic bag. Currently the nurse's duty is to call 911 and resuscitate. Under legal assisted suicide the nurse's duty might be changed, to placing a plastic bag herself as noted above. Or her duty might be seen as passive, to leave the patient in a comatose state, visiting later to see if the patient died in the interim. It is highly impractical to say that the nurse would be obligated to stay with such a patient. Patients in a coma may take 11-14 days to die of dehydration (known from the experience of deliberately dehydrating to death, non-dying patients). Ruth Phillips, *The legacy of Nancy Cruzan*, 6(2) Living World 16 (1992).

A failed attempt could result in a very damaged patient, which would encourage or even mandate the nurse to ascertain that her patient does not fail. Nursing practice eventually might extend to directly killing the patient who failed in the suicide attempt. Legal assisted suicide does not prohibit active euthanasia; initially, it merely does not "authorize" it. For example see Oregon Ballot Measure 16, Section 3.14.

(3) Hospital and long term care nursing practice would be changed under legal assisted suicide.

Under legal assisted suicide, some patients prescribed a lethal dose would choose to take the drug in the hospital or long term care facility. One proposed "safeguard" legislation recognizes that possibility on its face.

> "If the patient [who wishes to suicide] is an inpatient at a health care facility, one of the witnesses [to the request for suicide] shall be an individual designated by the facility."

Oregon Ballot Measure 16, Section 6, "FORM OF THE REQUEST." [Material in brackets added.] The nurse designated by the facility would be faced with assisting suicide at least to the extent of witnessing the patient's request, regardless of her moral, ethical and professional objections.

If the nurse on duty in a hospital or other inpatient facility knows of the patient's plan to suicide beforehand, her duty might change from trying to save the patient's life – to assisting with his death. Currently the nurse continues nursing care for the patient who is dying; turning the patient, suctioning secretions, administering medications, etc., to help the patient *live* comfortably. Under legal assisted suicide, the nurse's practice would change. The duty logically might be to do whatever would cause the patient to die sooner.

Under legal assisted suicide, the "worse" the nurse by present standards (that is, the faster and better at killing), the better for the patient. The "better" the nurse by present standards (that is, the more life-saving, caring), the worse for her patient under legal assisted suicide. The *amici* assert: This situation stands nursing practice on its head.

These vignettes look macabre, but they are not worst-case scenarios; they are the likely situations that nurses would encounter if the Courts of Appeal are affirmed. Immediately, intimately and inextricably, nurses would be inculpated in assisted suicide.

Nursing "care" would be redefined to include the killing of the patient, and assistance as the patient self-kills. Nursing theory would be developed to teach students how to "care" (or, in every accurate usage of the word, how *not* to "care") for patients committing suicide. Continuing education would be needed for current nurses, on how to assist patients being killed by self-administration of drugs. If assisted killing were extended to people unable to self-administer the drugs (as would be likely), nurses would be taught to kill patients directly.

Nursing education and curricula would be changed to incorporate the "new" ethic and law and nursing practice: Some patients would be given good care. Some patients' "good care" would include giving them prescriptions to kill

themselves. And some patients' "care" would include killing them.

c. Anticipation of legal assisted suicide in one state has caused its nurses to accept involvement.

The threat of legal assisted suicide in one state already has prompted a paper in which the nurses association accepts that nurses will be involved in their patients' suicide. In anticipation that legal assisted suicide would be implemented, and to prepare their members for that reality, the Oregon Nurses Association (ONA) adopted a position statement to guide nurses in the care of terminal patients under legal assisted suicide. Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995).

The ONA document asserts that the nurse's role under legal assisted suicide would be "to share information about health choices **that are legal**." [Emphasis added] Oregon Nurses Association, p. 3. This statement is evidence that nurses will be involved if assisted suicide is legal. Nurses would be expected to teach patients about the option of killing themselves. Mere legality (not any higher ethical standard) would be the defining parameter of the nurse's behavior.

Theoretically, under the Oregon "safeguard" legislation which proposed to make assisted suicide legal, the nurse could refuse to care for a patient who chooses to kill himself. But the ONA paper admits that if she couldn't transfer the patient, "the nurse has the responsibility to provide for ongoing end of life care." Oregon Nurses Association, p. 3. Transfer might be impossible if the nurse discovered the suicide attempt after the patient had taken the poison. Requesting and securing a replacement nurse from her agency (if even granted) could take longer than the patient had to live. Nurses could not opt out of legal assisted suicide, no matter what the language of any "safeguard" legislation adopted by a state legislature.

Nurses are competent to make professional judgments about the mental and physical status of their patients that would affect the appropriateness of a request for suicide.

Further, they are competent to make moral judgments for themselves, about the appropriateness of suicide for any person at any time. Regardless, under legal assisted suicide, the ONA paper asserts that the nurse would be involved and would be muzzled:

> "You may not subject your patients or their families to unwarranted, **judgmental** comments or actions because of the patient's choice [to kill himself]."

Oregon Nurses Association, p. 4. [Emphasis and material in brackets added].

The nurse would be involved, her professional judgment would be thwarted and her freedom of speech compromised under legal assisted suicide.

The ONA position paper is evidence that legal assisted suicide would inculpate nurses fully in assisted suicide, and to the detriment of the practice of the profession.

2. Legal assisted suicide would harm the ethics and law of nursing; the threat already has done harm.

a. Legal assisted suicide would erode the ethics and law of nursing.

The inculpation of nurses in assisting patients to kill themselves causes the degeneration of the ethics and law of nursing, which are based on six values (elaborated below): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. The position of the American Nurses Association (ANA) states the ethical foundation of nursing practice:

> "The goals of nursing are the promotion, maintenance, and restoration of health, the prevention of illness, and the alleviation of suffering. The social contract between nursing and society to meet these goals is based upon a code of ethics that is grounded in the basic ethical principles of respect for persons, the noninfliction of harm, and fidelity to recipients of nursing care. These principles command that nurses protect or preserve life, avoid doing harm, and create a relationship of trust and loyalty with recipients of nursing actions."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The ethical standards of conduct (a higher ideal) are used by lawmakers in making lower, legal minimum mandates. Nursing law is the minimum enforcement of nursing ethic. It is the arbitrarily drawn line that separates desired behavior (ethics) from mandated behavior (law). The law exists to guide people who have no higher ethic. People who will not do right voluntarily, can be made to do at least a minimum of "not wrong" with law.

Those people, and others who have no moral compass, will take the law as the highest, not the lowest, standard of behavior. For them, the law becomes the ethic. "It's legal, therefore it must be ethical" is the reasoning. If the nurse who assists suicide were acting legally, some then would assume that she was acting ethically, too.

As noted below regarding nurse participation in executions, the nursing profession nationally has not succumbed to that lowest level of behavior. The national nursing associations, such as the American Nurses Association (ANA) and the National Association of Prolife Nurses, set and promote professional standards of ethics. Those standards cannot be varied according to popularity poll, nor may they descend to whatever acts the popular will has made temporarily legal. As an analogy to assisted suicide: Nursing leaders have suggested that nurses who participate in executions – even if the act is legal – are so far below the ethical standard required of nurses, that their licenses should be revoked.

Assisting a patient to kill herself, merely because it is legal, should not change the standards of nursing practice and ethics; but it would. The legal standard of nursing would be so low that merely to meet it would violate nursing ethics. The standard of nursing ethics and nursing practice would inevitably be ratcheted down to a lower level commensurate with the law.

Some nurses would do whatever is legal. That is why it is not sufficient to say that nurses can protect the ethics of the nursing profession simply by voluntarily refusing to participate in legal assisted suicide. Unlike the isolated participation

in legal executions by a few nurses, *all* nurses are intimately involved in the lives and deaths of dying patients. Under legal assisted suicide, nurses would be inextricably inculpated in their patients' suicides. The erosion of the law would corrupt the ethic correspondingly. Law would lead instead of follow the ethic, and would irreparably harm the profession of nursing.

The ethics and the resulting law of nurses are based on the following six values held by nurses (and all the illness care professions): Doing No Harm, Doing Good, Being Free, Being Fair, Being True, and Life. J.K. Hall, *Nursing Ethics and Law* (1996). Discussion of each value follows with its resulting ethic and law and the changes that legal assisted suicide would cause. As the law deteriorates, so do the ethics.

DOING NO HARM

Legal assisted suicide would damage the nursing ethic and law based on the value, *Doing No Harm* (Non-maleficence). That value is enforced by criminal law, civil intentional tort law and licensure law. Currently, nurses can be prosecuted under their licensure law which in most states allows license revocation for conduct which can be characterized as gross incompetence or gross negligence. See, for example, Or. Rev. Stat. 678.111(b). Presently, assisting deliberately caused death in a patient could be characterized at least as gross incompetence or as gross negligence, if not intentional harm. If assisting suicide were legal, the nursing licensure law would have been dramatically changed.

Assisting deliberately caused death now would surely be "conduct derogatory to the standards of nursing," also grounds for licensure discipline in most states. See for example, Or. Rev. Stat. 678.111(f). Again, legalizing assisted suicide would change the licensure law. As noted above, the standards of nursing have been national parameters, not community or state standards subject to the vagaries of what lawmakers set. But the law will lead those who have no ethical guide, and if assisted suicide is legal, nurses who

assist will seem to meet the minimum standard of nursing practice.

Presently, the nurse whose terminal patient is being pressured to commit suicide may be obligated to report that as neglect or abuse of an elderly or dependent patient. See for example Or. Rev. Stat. 410.610 *et seq*. (elderly) and Or. Rev. Stat. 441.630 *et seq*. (nursing home). If assisted suicide were legal, such encouragement might be considered the right thing for family or nurse to do.

Under legal assisted suicide the enforcement of these laws preventing harm to the patient would change. "Safeguard" legislation (such as that passed in Oregon) would have to provide that nurses would not be subject to criminal or civil liability or professional disciplinary action for assisting suicide. Such law would erode the authority of the board that regulates nursing, and any other agencies that enforce the law that prohibits and punishes harm to patients. Allowing nurses to assist in suicide would erode the minimum ethic enforced by the law, and correspondingly lower the standards expected of nurses generally.

DOING GOOD

The nursing ethic based on the value *Doing Good* (Beneficence) is enforced in malpractice law. Currently, when nurses fail to do good (as a reasonable prudent nurse would do), even unintentionally, they are subject to liability. Currently, nurses are not relieved of their own liability for their actions by physician orders and actions or patient wishes; nurses are morally and legally liable for their own malpractice. See generally, *Nurse Liability for Own Malpractice*, 51 ALR 2d 970.

Legal assisted suicide would change the nursing malpractice law. The standard of care of the "reasonable prudent nurse" would be changed from obligation to *save* the patient's life, to obligation to help *end* it in some situations. As noted above, under legal assisted suicide, the nurse would be obligated to inform the patient about the availability of assisted

suicide. Regardless of her personal moral convictions or professional assessment that the patient can be helped short of suicide, the patient or survivors might bring an action for subsequent pain and suffering based on a negligence theory if she did not so inform.

On the other hand, nurses who did refer or assist the patient who sought assisted suicide, might also be liable. The theory of liability could be failure to assess adequately for depression or decisional capacity, or failure to challenge the prescriber's assessment and prescription if they were faulty.

The family member or the estate who learns about the nurse's involvement in the attempt might have a cause of action for malpractice or wrongful death. The family might notify the licensure board of the nurse's action, alleging failure of nursing care. (Though as noted above, the licensure board might be powerless to enforce standards after legal assisted suicide.)

BEING FREE

Legal assisted suicide would damage the nursing ethic based on the value *Being Free* (Autonomy), enforced by consent law. The nurses leave to other *amici* to elaborate on the obvious fact: The patient's autonomy must *not* be honored and he must be protected from himself, if he is not competent to make decisions. That is the situation if the patient is depressed or suffering from mental illness, which almost all suicidal patients are.

The right of the patient to refuse treatment is stronger than the grant of an entitlement (as in legal assisted suicide), but even that power of refusal is not absolute. The right is conditioned on the impact on other people; for example, the power to refuse a transfusion may be conditioned on the patient's responsibility for another person.

Nurses have some rights to their own autonomy. The patient's demand for treatment which transgresses the professional's ethics cannot be honored. For example, the patient's demand to remove a healthy body part (because the person wanted to qualify as disabled) must be declined by the ethical

physician. Even an *un*ethical doctor would face legal sanctions for performing such a procedure. Government cannot arbitrarily inculpate the professions in such entitlement, to the detriment of their fundamental liberty and property rights to practice their profession with autonomy.

A rough analogy to the damage to nurses' autonomy under legal assisted suicide: Imagine a law granting the entitlement to assisted suicide with the help of a police officer to accomplish the killing. The damage is obvious to the ethic of police officers, whose professional responsibility is to protect innocent life. As noted above, the reason to have a professional assist is to put her imprimatur on the act.

Another analogy of damage, to another profession that might serve as provider of assisted suicide (and whose ethics much of the public already consider to be below reproach) is the legal profession. A recent article describes the perception that lawyers will do whatever their clients order, without reservations based on personal integrity or professional ethics. The authors suggest, perhaps not tongue-in-cheek, that the legal profession might be the ideal suicide assistants. R.M. Sade & M.F. Marshall, *Legistrothanatry: A new specialty for assisting in death,* 39(4) Perspectives in Biology and Medicine 547 (1996).

The American Nurses Association addresses the fine line separating the patient's autonomy from the moral mandates and integrity of his nurse:

> "Though there is a profound commitment both by the profession and the individual nurse to the patient's right to self-determination, limits to this commitment do exist. In order to preserve the moral mandates of the profession and the integrity of the individual nurse, nurses are not obligated to comply with all patient and family requests. The nurse should acknowledge to the patient and family the inability to follow a specific request and the rationale for it."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.4.

BEING FAIR

Legal assisted suicide would damage the nursing ethic based on the value *Being Fair* (Justice), enforced by laws requiring equal treatment under the law. Other *amici* will discuss the laws that enforce fairness toward patients in this country. They include the due process and equal protection clauses of the Fifth and Fourteenth Amendments to the Constitution, the Americans with Disabilities Act, and the prohibition against discrimination toward some groups who are more likely to experience pressure to die if assisted suicide were legal.

Amici assert, as detailed above, that the fundamental fairness due nurses under the Fifth Amendment would be violated under legal assisted suicide.

BEING TRUE

Legal assisted suicide would damage the nursing ethic based on the value *Being True* (Loyalty), enforced at a minimum in law by contract law, confidentiality, informed consent, and by law requiring nurses to be advocates for patients. Nursing law mandates that nurses must be advocates for the patient, even if their action is counter to the physician or employer's order.

The changes in nursing practice that legal assisted suicide would force (elaborated above in descriptions of nurse involvement under 1.b.) are severe dislocations of the nurse's ethical and legal duties of loyalty to the patient. Under legal assisted suicide, the nurse's duty to advocate for the patient might become the duty to advocate death for the patient.

LIFE

Legal assisted suicide would damage the nursing ethic based on the value *Life*, enforced by all law that outlaws killing. Though mentioned last, this is the first value of nurses, or the one that underlies all others. The *sine qua non* of nursing ethic is promoting the life of the patient in all aspects, including the comfort of the patient and her value as

an individual. This is so, even and especially as the patient is dying. Promoting and protecting the dying patient's life cannot be subverted to mean assisting her deliberately to kill herself.

At present, the life of the individual is protected by the law, overridden only in extreme circumstances. For example, killing is justified only under narrow conditions such as self-defense, executions, or war.

Under the decisions of the Courts of Appeal, some lives would *not* be protected by law. People who are diagnosed "terminal" would not be protected from assisted suicide. But people who were not dying, *would* be protected from assisted suicide. The assumption underlying that situation: People who are not dying are more valuable than the dying.

Nurses do not discriminate in their care, between patients whose lives are less valued and more valued. This stratification of lives into levels of protection – some more valued, some less valued – is not a new concept. The framers wrote the U.S. Constitution, and courts subsequently have interpreted that Constitution, precisely to *prohibit* laws that classify lives in that way. Yet one of the decisions on review, responding to the state's contention that its principal interest is in preserving the life of all its citizens, answers:

> "[W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes."

Quill v. *Vacco*, 80 F.3d at 729 (2d Cir.1996).

b. The national standard of ethics for nurses is that nurses do not assist patients to kill themselves, but threat of legal assisted suicide in one state has caused erosion of that standard.

To state the obvious: The consensus of nursing ethics is that nurses do not assist patients to kill themselves.

The maintenance of the ethical integrity of the professions involved is one of the primary interests Courts weigh in

such cases as these. *Superintendent of Belchertown* v. *Saikewicz*, 370 N.E.2d at 426 (Mass.1977), *Satz* v. *Perlmutter*, 362 So.2d at 163 (Fla.1980). The court in *Superintendent of Belchertown* took care to find that its decision was in accord with the "prevailing ethical practice" of the profession. The prevailing ethical practice of the nursing profession is *not* to assist patients to deliberate death, evidenced by the following statements of ethics of American nurses.

The American Nurses Association maintains that nurses may not ethically assist suicide (as they would be asked to do under legal assisted suicide):

> "Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments. The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the Code for Nurses With Interpretive Statements (Code for Nurses) and the ethical traditions of the profession."

American Nurses Association, *Position Statement on Assisted Suicide* (1994) p.1.

The national Oncology Nurses Society endorsed the ANA position in 1995. Oncological Nurses Society, *Endorsement of ANA Position Statement on Active Euthanasia and Assisted Suicide* (1995). The American Association of Critical Care Nurses has endorsed as well.

The National Association of Prolife Nurses and its affiliates oppose assisted suicide in the strongest terms, believing it tantamount to euthanasia:

> "The public must be assured that we will not participate in euthanasia or refer people to individuals and organizations supporting euthanasia, and that we consider euthanasia to be medical murder."

Nancy Guilfoy Valko, *National Nurses Group Supports Resistance to Euthanasia*. National Association of Prolife Nurses (1994).

Though addressed to the prohibition against nurses' participation in executions, the following encompasses the ethical standard of the ANA for causing death in patients:

> "Regardless of the personal opinion of the nurse on the moral appropriateness of capital punishment, either generally or specifically, it is a breach of the ethical tradition of nursing, and its Code for Nurses, to participate in taking human life, even through a legally authorized civil or military execution."

American Nurses Association, *Position Statement on Capital Punishment* (1988).

The *amici* would add that it is a breach of the ethical tradition of nursing to participate in taking human life, even through a legally authorized nurse assisted suicide as would be possible under legal assisted suicide.

Further nurse ethical standards:

> "The nurse acts to safeguard the client and the public when health care and safety are affected by incompetent, unethical, or illegal practice of any person."

American Nurses Association, *Code for Nurses* (1986).

The nurse mandate to safeguard the patient from "any person" must include physicians or other nurses who prescribe or administer drugs to cause death.

And yet another ethical standard that nurses must not aid death:

> "Nurses . . . must take all reasonable means to protect and preserve human life when there is hope of recovery or reasonable hope of benefit from life-prolonging treatment. The nurse does not deliberately act to terminate the life of any person."

American Nurses Association, *Code for Nurses with Interpretive Statements* (1986).

As noted above under 1.c., the anticipation of legal assisted suicide in Oregon has resulted in a position statement by the Oregon Nurses Association. That paper admits that nurses would have to participate or assist in their patient's suicide in several ways –

> informing patients of "choices that are legal" (as noted above, to some nurses this would be tantamount to encouraging suicide),
> "providing for ongoing end of life care" for suiciding patients if the patient couldn't be transferred (very likely if the nurse learned of the suicide attempt after the prescription were ingested), and the nurse could make no "judgmental comments or actions because of the patient's choice [to kill himself]," muzzling the nurse's ethical or professional assessment of the patient's choice.

Oregon Nurses Association, *Death with Dignity Act Position Statement* (1995) p. 4 [Material in brackets added]. As can be seen, the threat of legal assisted suicide in Oregon resulted in a position paper from the ONA which copes with that potential reality, by lowering ethical standards to the minimum ethic: Whatever might be made legal is ethical.

In addition to the assault on their professional ethics, many nurses would have personal ethical problems in assisting suicide – though as outlined above and noted under the ONA paper, they would have little choice under legal assisted suicide. Considering the shrinking job market faced currently, nurses would be under great pressure to comply with the employer who requires them to participate with patient suicide.

Some nurses already have been disciplined with job suspension for six weeks for reporting (or for not reporting fast enough – the employer's version) an active euthanasia performed on a child by the physician. *Death at U.C. Med Center,* San Francisco Chronicle, 3 April 1995, A20; *UCSF suspends nurses who delayed reporting incident*, NURSEweek, First April 1995, 3, 20. Under legal assisted suicide, the pressure would increase on the nurse to look away from patient abuse or to lose her job.

Under legal assisted suicide nurses who are religious would face a compromise to the very fundamentals of their morality – encompassed in any version of "Thou shalt not kill." Exodus Chapter 20, Verse 13. Nurses who are not formally religious are no less spiritual, and no less harmed by such an egregious violation of their personal ethic.

Other *amici* will inform the Court of the fact that all medical associations in the world (save Holland's) oppose assisted suicide. They will describe the experience in Holland in which even the tacit legal approval of euthanasia and assisted suicide – far short of the outright legal assisted suicide as proposed by the Courts of Appeal – has become a large problem, for the society, the professions, and most of all the patients of that country.

3. Legal assisted suicide would inculpate nurses in assisting suicide, damaging the profession in the eyes of the public.

a. Under legal assisted suicide, some nurses *would* assist in patient killing.

No illusions may be indulged; under legal assisted suicide, some nurses would be ready, willing and able to assist suicide. Some would kill patients directly if assisted suicide were extended to the disabled who are unable to self-administer the drugs.

The experience of nurses in the 1930's under Germany's National Socialism is instructive. Though some would wish it not so, 1990's American nurses too would be vulnerable to pressures if killing were made legal. Under National Socialism, some nurses and their associations collaborated when Hitler's euthanasia program was legal.

Some German nurses deliberately administered barbiturates to mentally retarded children that they had selected; the children slept for long periods, developed pneumonia as a result, and died a "natural" death. The death certificates read "Pneumonia," but in the consensus of world opinion, ten and now fifty years after, those nurses caused the deaths of those children. *Testimony of Dr. Valentin Falthauser, 22-23 April 1948; and Nurse Mina Worle, 7 May 1948 (Kaufbeuren asylum)*, Heyde Trial, pp. 143-47, in Robert Jay Lifton, *The Nazi Doctors* (1986) p.55.

The nurse associations of Germany collaborated in changing the ethics of the profession to conform to the legal mandates of the National Socialist government. Hilde Steppe,

Nursing in Nazi Germany 14(6) West. J. Nurs. Res. 744 (1992). Some nurses were not, would not be, immune to pressures to eliminate the problem patient instead of eliminating the patient's problem.

b. If legal, future killing would be delegated to nurses.

In addition to the immediate consequences of legal assisted suicide to the profession, the *amici* have reason to worry about their even worse role in the future. Under legal assisted suicide *amici* believe assisted suicide would be extended to actual administration of "suicide" to the disabled and incompetent. Allowing only competent able patients to kill themselves with prescribed drugs inevitably would be held to discriminate against the disabled who can't self-administer the drugs, and against the incompetent who can't request the killing drugs. At that point, prescribing suicide or even direct euthanasia would fall to the nurses as does other dirty work.

In support of that prediction: Technical procedures always are delegated eventually. When blood pressure measurements were first available, only doctors were allowed to perform them. At present, the *amici* are confident that few members of the Court have ever had their blood pressure measured personally by a doctor. When first developed, the technology of intravenous medication was limited to doctors (as late as the 1970s it was not taught in nursing curricula), as was administration of chemotherapy, and virtually all intensive care technology, including interpretation of electrocardiograms.

Today, in various states, nurses can perform all those procedures; in addition, nurse practitioners may set broken bones, suture wounds, and prescribe almost all drugs that physicians can. Under legal assisted suicide, it would be a short matter of time before this last worst "technique" of assisting suicide would be delegated to the nurse.

c. Allowing nurses legally to assist suicide would result in deterioration of the public's trust in their profession.

The public's perception of nurses would change under legal assisted suicide as nurses came to be seen as people who assist with killing. The public would lose confidence in nurses, and would be suspicious of the nurse's intent when she nursed patients labeled "terminal." The social contract that nurses have with the public would be breached. The ANA believes that trust to be essential:

> "Nursing has a social contract with society that is based on trust and therefore patients must be able to trust that nurses will not actively take human life. The profession's covenant is to respect and protect human life (Nursing: A Social Policy Statement). Nurse participation in assisted suicide is incongruent with the accepted norms and fundamental attributes of the profession."

Position Statement on Assisted Suicide, p.4.

Assisting in deliberate killing of patients, either by prescribing self-administered medications (nurse practitioners), or by tacitly approving of the patient's decision to die by participating in their care as they suicide – would violate the nurses' social contract with their patients and result in the public's loss of trust in the profession.

If nurses could assist suicide legally, the public's perception of nurses would change. Nurses who could assist in suicide would be seen not as trusted advocates but as people who carry out orders regardless of their effect. They would not be seen as professionals with autonomy and independent judgment, but as lackeys who do the patient's or doctor's bidding no matter how heinous the morality of the order.

Patients would not trust nurses who were handmaidens to physicians prescribing death, and who were unquestioning, "nonjudgmental" servants to any patient with a prescription. At present, the wish to die to the nurse is a cry to help the patient to find reason to live. Under legal assisted suicide, it

would be a mandate to nurse the patient to deliberate death. The public's opinion of nurses could not help but decay.

The nurse's liberty to practice nursing as she knew it and chose it and learned it would be curtailed. Her property interest in working at her profession would deteriorate. Hers then would be a profession with an ethic of promoting or assisting patients to deliberate death, instead of to life.

CONCLUSION

Legal assisted suicide creates an entitlement to assistance with, and approval of, suicide. It inevitably will inculpate nurses in the killing of their patients. It would destroy the public's confidence in the profession of nursing, damaging the nurses' liberty and property rights to practice that profession. It purports to help patients who either do not wish to die (terminal patients, even those in pain) or who are treatable and would be treated if society valued their lives (terminal patients who are depressed and ambivalent). That unwanted, unneeded entitlement is granted to the awful detriment to the fundamental rights of nurses who wish to practice their profession uncorrupted.

Based upon the above, the decisions of the Courts of Appeal should be reversed and the cases remanded for disposition in accordance.

Respectfully submitted,

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APPENDIX

Statements of Interest

This brief *amici curiae* is submitted to the Court by people who will be uniquely and directly affected by the Court's decision in this case. *Amici Curiae* are:

The National Association of Prolife Nurses, nurses who promote and protect the lives of patients at all stages of life, was formed in 1973 with state affiliates and members in all states. Their activities on behalf of patients, and on behalf of nurses who protect patient lives, include legal representation, education, and organization. The members have supported an *amicus* brief to the Ninth Circuit in the case challenging the legalization of assisted suicide in Oregon still pending there.

The National Association of Directors of Nursing Administration in Long Term Care, the managers of facilities where some patients are cared for who would be subject to assisted suicide if legal, was formed in 1986, and has 30 state affiliates with 4000 members from all states. Their code of ethics mandates they support and promote quality of care for those individuals receiving long term care, and concern for those delivering long term care.

The Philippine Nurses Association of America, nurses of Philippine ethnicity who live and work in the U.S., was formed in 1979, and has 25 state affiliates with over 2000 individual members. Their endorsement of the Code of Ethics of the International Council of Nurses mandates they protect, promote and restore health when possible, prevent illness when possible, and alleviate suffering; thus

they believe the legalization of nurse assisted suicide and euthanasia will change the very essence of nursing practice.

The Scholl Institute of Bioethics, a group of professionals in medicine, law, psychology and religon, was established in 1986 because of concern for the increasing difficulty of bioethical decisions that both individuals and the medical profession are facing in relationship to today's modern advances in medicine and the growing euthanasia movement.

California Nurses for Ethical Standards, a non-profit educational and professional organization of nurses who promote in all respects ethical standards of health care, was established ten years ago in the state of California. The members believe that euthanasia and assisted suicide violate all nursing ethics codes.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, *et al.*,
Petitioners,
v.
TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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STATE OF WASHINGTON,
Petitioner,
v.
HAROLD GLUCKSBERG, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE AMERICAN GERIATRICS SOCIETY AS AMICUS CURIAE URGING REVERSAL OF THE JUDGMENTS BELOW

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48 pp

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
INTEREST OF AMICUS CURIAE	1
SUMMARY OF ARGUMENT	3
ARGUMENT	4
I. THE COURTS WERE MISLED BY MISPERCEPTIONS ABOUT END-OF-LIFE EXPERIENCES	4
A. The Patient-Plaintiffs Are Not Representative of Dying Persons Generally	4
B. Dying Is Mischaracterized as Unavoidably Dreadful	6
C. The Lower Courts Misperceived Current Shortcomings in Care at the End of Life as Persistent and Unchanging	9
II. THE COURTS BELOW MISTAKENLY CONCLUDED THAT PHYSICIAN ASSISTED SUICIDE IS NO DIFFERENT FROM FOREGOING LIFE-SUSTAINING TREATMENT	11
A. Descriptive Aspects Differentiate the Two Situations	12
B. Rights Against Interference Are Stronger Claims Than Those for Assistance	13
C. The Restriction of Physician Assisted Suicide to a Narrow Class of Persons Highlights Its Differences From Foregoing Life-Sustaining Treatment	14
D. The History of Familiarity With Foregoing Life-Sustaining Treatment Contrasts Sharply With the Lack of Experience With Physician Assisted Suicide	14

TABLE OF CONTENTS—Continued

	Page
III. THE CONSTRAINTS PROPOSED FOR THE PRACTICE OF PHYSICIAN ASSISTED SUICIDE PRESENT INTRACTABLE PROBLEMS	15
A. Terminal Illness	16
1. Subjective Determination	18
2. Statistical Determination	18
3. Disease Threshold	20
B. Competence	21
C. Undue Influence - Coercion	23
1. The Context of Care	23
2. Financial Considerations	24
D. Suffering	25
E. Physician Involvement	25
F. The Scope of Assistance	26
IV. THE COURT SHOULD VACATE THE ORDERS OF THE LOWER COURTS	27
CONCLUSION	29
APPENDIX	1a

TABLE OF AUTHORITIES

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	Page
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	Page
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	Page
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	Page
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TABLE OF AUTHORITIES—Continued

	Page
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INTEREST OF AMICUS CURIAE [1]

The American Geriatrics Society (AGS) is comprised of professional health care providers focused upon serving the health care needs of elderly persons. Founded in 1942, the AGS has 6,000 dues-paying members. The AGS sponsors conferences and seminars, articulates policy and practice guidelines, publishes a preeminent professional journal (*The Journal of the American Geriatrics Society*), and encourages improved health care services for elderly persons and research on the illnesses from which they suffer. As practitioners specializing in the care of the elderly, AGS members are particularly dedicated to improving how people live at the end of life and consequently have abiding concerns with the issues raised by initiatives to legalize physician-assisted suicide (PAS).

The AGS and its members have worked diligently to assure that even elderly persons with severe dependency and limited personal and family resources can count on reliable and effective diagnosis, treatment, prevention, rehabilitation and supportive care. The AGS has encouraged care providers, the elderly, and their families to adopt an optimistic and energetic approach to treatment of illness. However, geriatricians (including physicians, nurse practitioners, and other health-care professionals) also realize that all elderly persons die, and that serving people well in their old age requires incorporating that fact into judging various strategies for care. Just as we must strive to make available all potentially beneficial treatment, we must also strive to avoid interventions that are more harmful than beneficial.

Legalization of PAS would create a moral dilemma for geriatricians. Most elderly persons experience serious and

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[1] Each party has given its consent, in writing, to the filing of this brief amicus curiae. Their consent letters have been filed with the Clerk of the Court. Counsel gratefully acknowledges the valuable contributions made to this brief by Joanne Lynn, M.D., and Felicia Cohn, Ph.D. Dr. Lynn, a recognized authority on the care of the dying, is a board member of the AGS and chair of its Ethics Committee. Dr. Cohn is associated with Dr. Lynn in the Center to Improve the Care of the Dying.

progressive illness for extended periods before death and need significant social, financial and medical supports.[2] These resources too often are not available, are of inadequate quality, are not covered by insurance, and are not provided by public entitlement programs.[3] By collaborating in causing early deaths, when continuing to live has been made so difficult, geriatricians would become complicit in a social policy which effectively conserves community resources by eliminating those who need services. By refusing to assist with suicides because a patient's relative poverty and disadvantaged social situation is seen as coercive, geriatricians would condemn their patients, and themselves, to live through the patients' undesired difficulties for the time remaining.

This conundrum has prevented defining a defensible role for geriatricians in any legalized practice of PAS. These concerns have driven the members of the AGS to address this issue at a time when few professional organizations have done so. The AGS position statements on PAS and euthanasia are attached.[4] The AGS opposes legalization of PAS at this time. Elderly and frail persons would be put at risk, yet their interests and concerns have not been adequately addressed in the public discussion of these issues.

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[2] Marilyn Moon, *Medicare Now and in the Future* (2nd ed. The Urban Institute Press 1996); *see also* Jack D. McCue M.D., *The Naturalness of Dying*, 273 JAMA 1039-1043 (1995).

[3] Joshua M. Wiener, *Sharing the Burden: Strategies for Public and Private Long-Term Care Insurance* (1994); Marilyn Moon, *Medicare Now and in the Future* (2d ed. 1996); Carl Eisdorfer et al., eds., *Caring for the Elderly: Reshaping Health Policy* (The Johns Hopkins University Press 1989).

[4] *See* Appendix and AGS Ethics Committee, *The Care of Dying Patients*, 43 J. Am. Geriatrics Soc'y 577-578 (1995); AGS Ethics Committee, *Physician-Assisted Suicide and Voluntary Active Euthanasia*, 43 J. Am. Geriatrics Soc'y 579-580 (1995). *See also* Greg A. Sachs, M.D., et al., *Good Care of Dying Patients: The Alternative to Physician-Assisted Suicide and Euthanasia*, 43 J. Am. Geriatrics Soc'y. 553-562 (1995).

The AGS urges this Court to note that improving life at its end has only recently become the subject of research and innovation. The potential consequences of accepting or tolerating PAS are unknown. The AGS believes that continued debate on these issues is essential if there is to be wise policy. The AGS takes no position on the merits of PAS for the patients in the cases before the Court. Instead, the AGS urges this Court not to recognize a constitutional right to the practice of PAS. At this time, the Court should exercise restraint in deciding a matter that would be more appropriately left to the states and the people. The AGS adopts the legal argument advanced in the *amicus* brief of the Project on Death in America of the Open Society Institute, which contends that the matter is not yet ripe for constitutional adjudication. The AGS limits this *amicus* brief to a presentation of a medical perspective on the uncertainties that require study and resolution before PAS could be implemented as the policy of any jurisdiction, or recognized as a constitutional right.

SUMMARY OF ARGUMENT

The courts for the Second and Ninth Circuits relied on three serious misperceptions in overturning state laws prohibiting PAS.[5] First, the courts were misinformed as to how people live while dying in the United States. Contrary to the courts' apparent assumptions, the plaintiff-patients in *Quill* and *Compassion in Dying* do not represent the usual situation of persons facing the end of life; severe pain and other symptoms can be relieved for persons near death; and health care generally and at the end of life is undergoing major changes.

Second, the lower courts mistakenly concluded that there is no significant difference between PAS and foregoing life-sustaining treatment. From a medical standpoint, however, clinical, definitional, and procedural considerations reveal important distinctions. These differences add

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[5] *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996); *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996).

to the legal, ethical, and historical distinctions identified by this court in *Cruzan*.[6]

Third, the courts below mistakenly condition their holdings upon the erroneous assumption that six restrictive criteria or safeguards can be easily identified and implemented: that the patients be (a) terminally ill, (b) competent, (c) suffering, (d) acting voluntarily and (e) seeking assistance in obtaining a means of suicide (f) which will be available only from a physician. In fact, as the discussion that follows makes clear, the medical profession has no adequate definitions for some of these criteria and lacks experience with all of them, making it unreasonable to believe that legislatures or courts could easily design procedures to ensure that each criterion could be met and could be sustained.

In view of the misperceptions upon which the decisions below were based, and the dearth of experience and knowledge that would be necessary to implement the exercise of a right to PAS, the AGS respectfully submits that a decision by this Court to constitutionalize PAS would be, at best, seriously premature.

ARGUMENT

I. THE COURTS WERE MISLED BY MISPERCEPTIONS ABOUT END-OF-LIFE EXPERIENCES.

A. The Patient-Plaintiffs Are Not Representative of Dying Persons Generally.

The named patients in the cases before the Court are dying in ways that do not characterize how people generally die in the United States. The identified patients all have a single, well-defined disease: three suffer from AIDS, two from cancer, and one from emphysema. Their situations thus fail to reflect the multiple diseases and uncertain prognoses that are much more common in advanced old age. Patient-plaintiffs' ages average 56 years. Not

[6] *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990).

one of the named plaintiffs is as old as the median age of death in the United States, 77 years.[7] None is characterized as poor, without family, or living in nursing homes. All have physicians, and none mention problems of access due to inadequate health insurance. This sample thus falls far short of representing the array of problems and concerns which should inform a determination of the constitutionality, or even the wisdom, of allowing PAS. The relative simplicity of the medical and social situations of these patients appears to have misled the lower courts into believing that PAS is the only or best response to those patients' problems.

Much has changed about how people come to the end of their lives in the United States. No more than a century ago, dying afflicted every decade of adult life, nearly evenly.[8] The most common causes of death were infections and accidents, which generally allowed little time between onset and death. Even cancer and heart disease were discovered late and the lack of effective treatment meant that death often occurred shortly after diagnosis.

Average life spans have also increased. Now, median life expectancy is 79 for women and 72 for men. Among those who survive to age 65, median age at death is 84 for women and 80 for men.[9] The usual causes of death now include cancer, heart disease, other organ system failures, and dementia, all of which are illnesses that ordinarily cause progressive disability over more than a year.[10] Typically, persons dying in their eighties and older succumb to a combination of loss of reserve capacity in aging

[7] Projection for the year 2000 is 76.7 years. *See* U.S. Bureau of the Census, *Statistical Abstract of the United States: 1995*, 86 (115th ed. 1995).

[8] Council on Scientific Affairs, American Medical Association, *Good Care of the Dying Patient*, 275 JAMA 474-478 (1996).

[9] Reports for 1993 for median life expectancy from birth, and for 1992 for median life expectancy at age 65. *Supra* note 7.

[10] *See* note 8, *supra*.

organs, deficiencies in daily functioning, and diseases with specific etiology.[11]

Modern society must learn how to assure that dependent and disabled persons can live well, despite living for a long time with eventually fatal illnesses. Prognosis is ordinarily uncertain. Poverty and isolation are common. Nearly one in five dies in a nursing home.[12] Depression and other psychiatric problems are common and largely unrecognized.[13] Characterizing the issue as simply acquiescing in the patient's request to end his suffering, as the courts below did, is much more difficult when one imagines a slowly failing elderly widow who is blind, nearly deaf, disabled, and in a Medicaid nursing home, than when the claimant is a younger patient with a predictably fatal illness.

B. Dying Is Mischaracterized as Unavoidably Dreadful.

Contrary to the apparent assumptions of the courts below, fatal illness does not have to mean severe pain and suffering. The Ninth Circuit's opinion repeatedly describes dying as "painful, protracted, and agonizing."[14] The Ninth Circuit then contrasts this fate with death by assisted suicide which lets a patient: "end his life peacefully and with dignity."[15]

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[11] R.R. Kohn, *Cause of Death in Very Old People*, 247 JAMA 2793-2797 (1982).

[12] National Center for Health Statistics, *Vital Statistics of the United States, 1991*, Vol. 2, Mortality, Part A. Sect. 1, Washington, D.C.: Government Printing Office, 1996:380-1. (DHHS publication no. (PHS) 96-1101).

[13] W. Breitbart, *Suicide Risk and Pain in Cancer and AIDS Patients* in: CURRENT AND EMERGING ISSUES IN CANCER PAIN: RESEARCH AND PRACTICE, 49-65 (C.R. Chapman & K.M. Foley 1993).

[14] *Compassion in Dying*, 79 F.3d at 839; *see also id.* at 812.

[15] *Id.* at 824. *See also id.* 814: ". . . a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent."

However, most people die quietly, most often in their sleep.[16] Hospice and palliative care programs have demonstrated that no dying person must live with overwhelming pain or other severe physical symptoms. Severe and persistent pain affects about half of cancer patients[17] and one quarter of dying persons generally.[18] Sophisticated palliative care relieves pain for most of these patients without confusion or substantial sedation. Intractable pain that can be relieved only by inducing sedation affilicts less than 3%, mostly very near the end of life.[19] Aggressive palliative care and sedation near death are already permissible. So is the removal of artificial nutrition and hydration[20] that were mentioned as sustaining two of the plaintiff-patients.

However, the standard of care lags behind what is possible to achieve, due both to barriers meant to limit the availability of narcotics and to delay in the adoption of

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[16] D.J. Foley, et al., *Recounts of Elderly Deaths: Endorsements for the Patient Self-Determination Act*, 35 The Gerontologist 119-121 (1995); "I have seen agony in death only once, in a patient with rabies," Lewis Thomas, *The Lives of a Cell* (Bantam Books 1974).

[17] John J. Bonica, *Cancer Pain* in: THE MANAGEMENT OF PAIN, vol. 1, 400-460 (John J. Bonica ed. 1990).

[18] The SUPPORT Investigators, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients: The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments (SUPPORT)*, 274 JAMA 1591-1598 (1995).

[19] T.E. Quill, et al., *Assisted Death And Physician-Assisted Suicide* 328 New Eng. J. Med. 965-966 (1993); J. Lynn, *Assisted Death and Physician-Assisted Suicide* 328 New Eng. J. Med. 964 (1993); *see also* R. Melzack, et al., *The Brompton Mixture: Effects On Pain In Cancer Patients*, 115 Can. Med. Ass'n J. 125-129 (1976); J.N. Morris, et al., *Last Days: A Study Of The Quality Of Life Of Terminally Ill Cancer Patients*, 39 J. Chronic. Dis. 47-62 (1986).

[20] *Cruzan*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J.), *cert. denied*, 429 U.S. 922 (1976); *see also* J. Lynn ed., *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water* (Indiana University Press 1989).

better practices by the health care professions.[21] Public policy should more vigorously encourage reliable relief of symptoms, but PAS is never the only option to relieve uncomfortable symptoms in a person near death.

How society arranges services to support care of those at the end of life has profound effects upon how that life can be lived. Life just before death can be especially precious and important. When supported and comfortable, dying persons ordinarily accomplish important tasks, such as saying farewells, disposing of property, completing life projects, and enjoying their remaining days. The courts below do not seem to have taken account of this possibility. *See, e.g., Quill,* 80 F.3d at 729.

Many persons consider suicide or wish for early death while they are angry or suffering. Since persons feeling worthless often test others to see whether these views are shared, encountering agreement actually functions to affirm the denigration of value. To offer PAS at this time does not merely offer an option but also affirms feelings of worthlessness or devaluation.[22] Since, when comfortable and comforted, most patients feel that this was an unexpectedly important time,[23] encouraging supportive care

[21] D.E. Joranson, *Availability of Opioids for Cancer Pain: Recent Trends, Assessment of System Barriers, New World Health Organization Guidelines, and the Risk of Diversion,* 8 J. Pain Symptom Mgmt. 353-360 (1993); *see also* N.J. Cherny, et al., *Opiod Pharmacotherapy in the Management of Cancer Pain: A Survey of Strategies Used by Pain Physicians for the Selection of Analgesic Drugs and Routes of Administration,* 76 Cancer 1283-1293 (1995); World Health Organization, *Cancer Pain Relief and Palliative Care: Report of a WHO Expert Committee.* WHO Technical Report Series, No. 809 (World Health Organization 1990).

[22] "[I]n agreeing to euthanize or assist a patient in suicide, one may be confirming the patient's sense that life has no more meaning or purpose, and this may be the wrong message to convey at such a vulnerable period in the patient's life." Breitbart, *supra* note 13, at 61.

[23] *The Hospice Experiment: An Alternative in Terminal Care* in: THE HOSPICE EXPERIMENT, 1-15 (Vincent Mor, et al., eds., 1988).

and discouraging suicide seems well within the purview of wise public policy.

C. The Lower Courts Misperceived Current Shortcomings in Care at the End of Life as Persistent and Unchanging.

Discussions about PAS are clouded by the paucity of reliable information regarding death in the United States.[24] Nevertheless, this is clearly a time of great ferment. Research in palliative care has developed considerably in the past twenty years.[25] About 61% of Americans die in hospitals and 17% in nursing homes, with the proportion of deaths in nursing homes increasing and those in hospitals decreasing.[26] In 1970, the standard of practice was to attempt resuscitation for virtually every person who died.[27] Now, foregoing life-sustaining treatment is commonplace,[28] especially for those with poor prognoses for survival. Resuscitation is now attempted for only about 10% of seriously ill persons who die in hospitals.[29] In the past, treatments were often continued for patients with poor prognoses and small chances of recovery.[30]

[24] Indeed, the only description of sequential seriously ill patients dying in hospitals in the United States was done in 1904. W. Osler, *Science and Immortality* (The Riverside Press 1904). *See also supra* note 8.

[25] Derek Doyle, et al., eds., *Oxford Textbook of Palliative Medicine,* 4 (Oxford University Press 1993). One recent study of certain seriously ill persons in hospitals has been influential, but it addressed only a small subset of the dying, *supra* note 18.

[26] M.A. Sager, et al., *Changes In Location Of Death After Passage Of Medicare's Prospective Payment System: A National Study,* 320 New Eng. J. Med. 433-439 (1989); *supra* note 12.

[27] Leslie J. Blackhall, *Must We Always Use CPR?* 317 New Eng. J. Med. 1281-1285 (1987); *In re Quinlan,* 355 A.2d 657 (N.J. 1976); Alan Meisel, *The Right to Die* (2d ed. John Wiley & Son 1995).

[28] J.M. Teno, et al., *Do Formal Advance Directives Affect Resuscitation Decisions and the Use of Resources for the Seriously Ill Patients?,* 5 J. Clin. Ethics 23-30 (1994).

[29] *Supra* note 18.

[30] E.g., *Cruzan,* 497 U.S. 261.

It is important to consider the major changes that are now reshaping health care generally. The rise of managed or capitated arrangements for service delivery and financing and the shift toward competing on costs rather than quality are rearranging relationships and roles. The impact on end-of-life care is not yet clear, but it is likely to include more reluctance to provide expensive care or to encourage patients and families to seek prolonged survival.[31]

The lower courts accepted a descriptive claim that PAS already exists as a clandestine but widely acknowledged practice.[32] AGS leadership is not familiar with situations in which this is true, and it seems unlikely. Three-quarters of all deaths happen in institutions where a regularized practice would require the collusion of a large number of persons, which seems implausible. Little reliable evidence characterizes the rate and nature of actual instances of PAS.[33] Courts should not rely upon presumptions and unsubstantiated reports in such a matter.

The constitutionality of PAS should not be resolved by reference to atypical situations and reliance upon misperceptions, as happened in these cases. Consideration of the role of PAS must be part of a broader examination of how this society should care for people with fatal illness and is therefore an endeavor more properly undertaken

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[31] S.H. Miles, et al., *End Of Life Treatment In Managed Care. The Potential And The Peril*, 163 West J. Med. 302-305 (1995).

[32] *Compassion in Dying*, 79 F.3d at 801, 828.

[33] All surveys of physician practices or attitudes are of limited validity due to low response rates, biased questions, or potential violations of confidentiality. Some insight is available in: A. L. Back, *Physician-Assisted Suicide And Euthanasia In Washington State. Patient Requests And Physician Response*, 275 JAMA 919-925 (1996); *see also* review of surveys in: K.M. Foley, *Pain, Physician-Assisted Suicide, and Euthanasia*, 4 Pain Forum 163-178 (1995); R. Sean Morrison & Diane E. Meier, *Physician-Assisted Dying: Fashioning Public Policy with an Absence of Data*. Generations 48-53 (Winter 1994).

by state legislatures and professional and lay organizations than by the federal judiciary.

II. THE COURTS BELOW MISTAKENLY CONCLUDED THAT PHYSICIAN ASSISTED SUICIDE IS NO DIFFERENT FROM FOREGOING LIFE-SUSTAINING TREATMENT.

The lower courts erred in finding no justification for distinguishing PAS from foregoing (withdrawing and withholding) life-sustaining treatment (FLST). However, significant medical, legal, and societal distinctions exist between the two practices and fatally undermine the conclusion that they are entitled to the same legal status. The AGS defines PAS as "[w]hen a physician provides either equipment or medication, or informs the patient of the most efficacious use of already available means, for the sole purpose of assisting the patient to end his or her own life." FLST is defined as "[w]hen medical intervention is either not given or the on-going use of the intervention is discontinued, allowing natural progression of the underlying disease state."[34] Major American medical associations and public committees and commissions[35] have recognized the distinctions between PAS and FLST.

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[34] AGS Ethics Committee, *PAS and Voluntary Active Euthanasia*, 43 J. Am. Geriatrics Soc'y 579-580 (1995), which is printed in the appendix.

[35] *American College of Physicians Ethics Manual*, 3rd ed. 117 Ann. Internal Med. 947-960 at 949 (1992); New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 102 (May 1994); President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment* (March 1983); *see also* The Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* (Indiana University Press 1987); *Guidelines for State Court Decisionmaking in Life-Sustaining Medical Treatment Cases, A Project of the National Center for State Courts* (2d ed., West Publishing Company 1993).

A. Descriptive Aspects Differentiate the Two Situations.

In addition to definitional differences and historical precedent, the situations involving PAS and FLST are associated with important moral and practical differences, including differences in access to medical care, in the practical effects of decisions, and in clinical intent.

Patients wishing to forego treatment are generally already receiving medical attention, and they have life-sustaining treatment available if desired. Thus, FLST decisions are implemented only when the life-sustaining treatment is unwarranted. However, for those seeking PAS, suicide may become a substitute for valuable but inaccessible medical attention. Persons seeking PAS may not know about, nor have available, other options for treatment, whether because of financial need, because their physician has inadequate skills,[36] or because social or ethnic barriers intervene.

Patients receiving life-sustaining treatment are usually very sick and close to death, so that even aggressive intervention is unlikely to lengthen their lives appreciably. With PAS, however, an individual may be giving up a more extended period of life. Fear of suffering and of losing dignity, along with a desire to control circumstances of death, may prompt a request for assistance in suicide before suffering might become unbearable.[37]

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[36] J.H. Von Roenn, et al., *Physician Attitudes and Practice in Cancer Pain Management—A Survey from the Eastern Cooperative Oncology Group*, 119 Ann. Internal Med. 121-126 (1993); *see also* Clive Seale, Ann Cartwright, *The Year Before Death* 186 (Ashgate Publishing Company 1994); American Board of Internal Medicine, *Caring for the Dying: Identification and Promotion of Physician Competency* (American Board of Internal Medicine 1996).

[37] Timothy Egan, *As Memory and Music Faded, Oregon Woman Chose Death*, N.Y. Times, June 7, 1990, at A 1:2; *see also* Marshall B. Kapp, *Old Folks on the Slippery Slope: Elderly Patients and Physician-Assisted Suicide*, 35 Duquesne L. Rev. 445-455 (1996); *see also* Breitbart, *supra* note 13.

In FLST, the intent is not to bring about the patient's death but to respect the patient's wishes not to be subjected to undesired treatment. Once medical treatment is withdrawn or withheld, the underlying disease process usually leads to the patient's death, though some survive. Although a physician sometimes physically removes the life support, the underlying disease and not the physician's action is ordinarily considered the cause of death. Failure to remove the undesired treatment would amount to battery, an unconsented touching. In PAS, the physician may be acting in accord with the patient's wishes, but death results from a drug overdose rather than a natural course of dying.

The Second Circuit's opinion also appears to suggest that PAS follows from aggressive pain management (80 F.3d at 729). Good pain management, however, usually prolongs life, and even very high doses of opioids rarely cause respiratory depression in patients who have been taking them for more than a few days.[38] Further, good palliative care aims to eliminate the suffering, whereas PAS succeeds only by eliminating the sufferer.

B. Rights Against Interference Are Stronger Claims Than Those for Assistance.

This Court has established that patients have the authority to forego life sustaining treatment, based on the requirement that the patient's informed consent is required for medical intervention.[39] The authority to

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[38] *"Respiratory depression.* This rarely presents a problem if the oral morphine dose is titrated carefully against the patient's pain, for pain is a respiratory stimulant. Tolerance to respiratory depression develops rapidly so that high doses of morphine can be used if necessary, without significant risk." Cicely Saunders et al., *Living with Dying: A Guide to Palliative Care* 23 (3rd ed. Oxford University Press 1995); *see also* American Pain Society, *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*, 23 (3rd ed. American Pain Society 1992; Marcia Angell, M.D., *The Quality of Mercy*, 306 New Eng. J. Med. 99 (1982).

[39] *Cruzan*, 497 U.S. 261 (1990). *See also In re Quinlan*, 355 A.2d 647 (1976); Mark E Williams, M.D., *The American Geriatrics*

forego life-sustaining treatment is thus a right to prevent unwanted bodily intrusion. Withdrawing or withholding a treatment to honor the patient's refusal of consent is not a matter of providing a patient with assistance but one of leaving the patient alone. Physicians may not impose treatment on a patient who refuses that treatment, even if the physician believes that the treatment will benefit the patient. This right to be left alone does not imply any corollary right to receive a form of assistance such as PAS.

C. The Restriction of Physician Assisted Suicide to a Narrow Class of Persons Highlights Its Differences From Foregoing Life-Sustaining Treatment.

FLST is an option for all treatments and all patients, just like any other medical decision. If PAS were equivalent to FLST, it should be available to all patients. Yet both courts below and all current legislative proposals restrict the right to PAS to a certain category of patients—those that are terminally ill, competent, acting voluntarily, and suffering. Unlike FLST, no proposal allows PAS to be directed in advance or by surrogate decision makers. The uniform agreement on such restrictions clearly suggests that the courts, the legislatures, and the policymakers recognize clear distinctions between PAS and FLST.

D. The History of Familiarity With Foregoing Life-Sustaining Treatment Contrasts Sharply With the Lack of Experience With Physician Assisted Suicide.

As this Court recognized in *Cruzan*, the right to reject life-sustaining medical treatment has had a long history of public acceptance, from legal, ethical, and medical perspectives.[40] Rooted in the common law doctrine of informed consent and recognized by courts, legislatures,

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Society's Complete Guide to Aging & Health, 119 (Harmony Books 1995); *supra* note 34.

[40] *Cruzan*, 497 U.S. 261 (1990); *see also In re Quinlan*, 355 A.2d 647 (1976); *see also* Alan Meisel, *The Right to Die* (2d ed. 1995).

and the health care professions, a consensus has emerged that persons generally have the right to refuse medical interventions, even though death may result.

In sharp contrast, no such consensus surrounds the practice of PAS. It has no common-law basis and has not been recognized widely by courts, legislatures, the public, or the medical profession. Most states have statutes prohibiting the practice of PAS—similar to the New York and Washington statutes struck down by the courts below in these cases. The practice has been approved by the voters in only one state, Oregon, where an initiative passed by a narrow margin but has not yet been implemented. The lack of any substantive experience with PAS, and the myriad restrictions attached to every proposed formulation of a right to request it, show that PAS is considered quite differently by all—its proponents, the law, health care providers, and the public.

III. THE CONSTRAINTS PROPOSED FOR THE PRACTICE OF PHYSICIAN ASSISTED SUICIDE PRESENT INTRACTABLE PROBLEMS.

As noted above, the plaintiffs below sought PAS only for a limited class of persons. Accordingly, the right to assisted suicide recognized in both cases is confined to adult patients who have terminal illnesses; are mentally competent; suffer from chronic and/or severe pain; and make a voluntary request for PAS. In addition, the only authorized method of assistance is through a physician's prescription of lethal medication which the patient must self-administer.

The Second and Ninth Circuits found a constitutional right to PAS conditioned upon these criteria, which they assumed would also function as safeguards to prevent mistakes or abuse. As the discussion below demonstrates, however, those decisions were based upon erroneous assumptions about the feasibility of both defining and applying the eligibility criteria. In fact, if PAS were to be implemented, determining the eligible population

would be intractably difficult and the proposed constraints would likely fail to provide the safeguards upon which the lower courts' decisions were based.

A. Terminal Illness.

Various statutory proposals and the cases before this Court contemplate that PAS will be authorized only for those who are "terminally ill." [41] The opinions below suggest that limiting the category to "terminal illness" helps to make the shortening of life acceptable and presume that the category can be clearly delineated. The Second and Ninth Circuits dismissed arguments asserting the difficulty of determining when a patient is "terminally ill," noting that "terminal illness" and "terminal condition" have been "defined repeatedly . . . in a model statute, the Uniform Rights of the Terminally Ill Act, and in over 40 state natural death statutes." [42] In actuality, such judgments are notoriously difficult to make. Indeed, because terminal illness or terminal condition is so difficult to define, the new Uniform Health-Care Decisions Act,[43] which supersedes the Uniform Rights of the Terminally Ill Act, upon which the Ninth Circuit partially relied, omits any reference to terminal condition

[41] Courtney Campbell, et al., *Conflicts of Conscience: Hospice and Assisted Suicide*, Hastings Center Report 36-43 (May-June 1995); Charles H. Baron, et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 333 Harvard Journal on Legislation 1-34 (Winter 1996); Oregon Death with Dignity Act, Ballot Measure 16 (passed Nov. 8, 1994); *Quill*, 80 F.3d at 731; *Compassion in Dying*, 79 F.3d at 838.

[42] "[W]hile defining the term 'terminally ill' is not free from difficulty, the experience of the states has proved that the class of terminally ill is neither indefinable nor undefined," *Compassion in Dying*, 79 F.3d at 831. *See also Quill*, 80 F.3d at 731 (stating that "it seems clear that most physicians would agree" on when the condition of "final stages" of terminal illness occurs).

[43] Uniform Health-Care Decisions Act, approved by the National Conference of Commissioners on Uniform State Laws at its conference held July 30-August 6, 1993, and approved by the American Bar Association on February 7, 1994.

and does not attempt to define terminal illness. The reasons for this omission have been explained as follows by David English, the reporter for this new Uniform Act: "Most existing advance directive legislation becomes effective only if a patient is in a 'terminal condition,' or is 'permanently' unconscious. Such restrictions have severely limited the usefulness of many state statutes and, indeed, have rendered them virtual nullities." [44]

As the drafters of this new Uniform Act thus recognized, terminal illness is notoriously difficult to define, and the working definitions of "terminal illness" for hospice or advance directive legislation are neither relevant nor reassuring, as the courts below erroneously concluded.

Hospice programs, for example, enroll mostly persons with some particular cancers.[45] Referral to hospice is most often initiated when such a patient experiences a deterioration in function, weight and comfort, usually three to six weeks ahead of death.[46] For cancer, then, the clinical course dictates timing, which is much shorter than the hospice statutory prognosis requirement of six months. Other illnesses do not regularly have such a final, relatively distinct, phase of clinical deterioration and they are engendering problems when referred into hospice.[47]

[44] See English and Meisel, *Uniform Health-Care Decision Act Gives New Guidance*, 21 Estate Planning 355, 359 (1994).

[45] N.A. Christakis & J.J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172-178 (1996).

[46] J. Lynn, *Caring At The End Of Our Lives*, 335 New Eng. J. Med. 201-202 (1996); J.N. Morris et al., *Last Days: A Study Of The Quality Of Life Of Terminally Ill Cancer Patients*, 39 J. Chronic Dis. 47-62 (1986).

[47] Hospice programs are being scrutinized by the Dept. of Health and Human Services' Office of the Inspector General, with disagreements on prognosis as hospice expands to enroll patients dying of chronic diseases. J.G. Brown, *Review Of Medicare Hospice Beneficiary Eligibility In The Commonwealth Of Puerto Rico* (DHHS, OIG, March 1996). *See also* Standards and Accreditation Commit-

A more rigorous definition of terminal illness seems necessary for PAS, since PAS has such significant and irreversible consequences. Three general approaches might be used in attempting to define the category "terminally ill": subjective judgment, statistical criteria, or a disease severity threshold. An examination of each of these reveals crippling problems.

1. *Subjective Determination.*

Some person or persons could be designated to judge whether a patient is "terminally ill," using information about the patient's situation, prognosis, care needs, and preferences. At present, the patient, family, and professional caregivers negotiate the designation while discussing plans and making decisions. The label then marks a change from a strategy of correcting abnormalities with the expectation of long survival to a strategy focusing on function, comfort, and emotional and spiritual support with the expectation of death.

In routine patient care, the timing of this change in focus does not much matter. The various participants can arrive at the designation at somewhat different times. However, the obvious variation in and diffuseness of this process would be troubling in the context of determining eligibility for authorizing PAS, and the fact that availability of PAS would be contingent on a designation of being terminally ill may result in pressure to accelerate or resist the label.

2. *Statistical Determination.*

Defining terminal illness with an explicit statistical threshold seems to offer clarity: a person is either below or above that threshold. However, this approach fails as it encounters at least four serious barriers.

First, the data necessary to calculate estimates which can be compared with a legislated statistical threshold is

tee, Medical Guidelines Task Force, *Medical Guidelines for Determining Prognosis in Selected Non-Cancer Diseases* (2d ed. National Hospice Organization 1996).

only rarely available. Very little research addresses the issue.[48] Most people will die of conditions that are not predictable with a statistical model.[49]

Second, the threshold is unavoidably arbitrary, with many borderline cases and unavoidable errors of over-inclusion and underinclusion. Any threshold will include people who will live a long time; the rate increases with more inclusive thresholds. A population in which each person has exactly a 25% chance to live six months will have one in four persons still alive at six months. The threshold should include all who will soon die of a serious chronic disease. However, some diseases are intrinsically unpredictable, even very close to death.[50] No reason justifies setting the threshold at any particular point, thus rendering any threshold arbitrary and subject to dispute.

Third, any specific threshold is inconsistent with current usage of the category. The popular conception of "termi-

[48] APACHE III and similar systems estimate the risks of dying during a particular hospitalization for very seriously ill patients in hospital intensive care units. W.A. Knaus et al., *The APACHE III Prognostic System. Risk Prediction of Hospital Mortality for Critically Ill Hospitalized Adults*, 100 Chest 1619-1636 (1991). SUPPORT's formula allows estimation of survival throughout the ensuing six months, but only for certain seriously ill patients with nine specific diseases, treated in hospitals. W.A. Knaus, *et al.*, *The SUPPORT Prognostic Model: Objective Estimates of Survival for Seriously Ill Hospitalized Adults*, 122 Ann. Internal Med. 191-203 (1995). Other available formulae are even more restricted in population, setting, or data required.

[49] The estimate varies also because other predictions can arise from one research database.

[50] Prognoses are surprisingly optimistic very near to death. Lung cancer patients in one study had a median prognosis of 17% to live two months on the day before death, and 50% just one week before death. Those dying of congestive heart failure, however, had a prognosis of more than 60% to live two months, and more than 40% to live six months, on the day before death. So, any criterion requiring less than a 50-50 chance to live two months would exclude virtually all of those who die with congestive heart failure. J. Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duquesne L. Rev. 311-336 (1996).

nal illness" mainly deals with cancer, neurological degenerative disease, and AIDS patients, all persons who have no available treatment, are losing weight and function, and who are psychologically "ready" to die. Most persons dying of chronic organ system failure will be excluded with a restrictive threshold and many persons with substantial opportunities for treatment and prolonged survival will be encompassed within an inclusive threshold.[51]

Fourth, the prognosis for survival can depend upon patient and physician choice and availability of treatment. A person with diabetes could stop insulin, a person with a feeding tube could stop its use, or a person with heart disease could be refused for transplant. If thereby such a person becomes "terminally ill," then the category is disquietingly dependent upon volitional actions rather than patient status.

Thus, defining the category of terminal illness with a statistical threshold would be arbitrary and certain to overinclude and underinclude substantial populations.

3. *Disease Threshold.*

The third way to define "terminal illness" ties the classification to clinically significant and morally important events, such as the recurrence of cancer in a distant site or the onset of fecal incontinence in a demented person.

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[51] *Id.* Half of all persons who die of lung cancer today will have had a prognosis of better than 30% to live 2 months, just one week ago, so any more restrictive threshold will miss most persons dying of lung cancer. Conversely, such a threshold will include many persons with acute respiratory, cardiac, or liver failure, who usually are vigorously treated. In fact, they qualify for transplantation only when they become so severely ill. If the category were expanded to include everyone with up to a 50% chance to live six months, most nursing home residents would qualify. If the category were restricted to those with a 1% chance to live two months, not only would one exclude virtually all cancer patients but those in the category would be so sick that they would, on average, die within a day. *See also* J.M. Teno, et al., *Prognosis-Based Futility Guidelines: Does Anyone Win?*, 42 J. Am. Geriatrics Soc'y 1202-1207 (1994).

However, an individual's status is not well characterized by the extent of one serious disease. Rather, a person's future is shaped by a variety of illnesses; reserve capacity of various organs; social situation; personal preferences; and treatment availability, use, and response. Thus, many of the patients included will actually have long expected life spans. This method is also afflicted with problems described above with regard to a statistical criterion.

Thus, no approach to defining terminal illness offers a simple and feasible method for determining who should have access to PAS. The problems appear to be intractable and no experience yet shows that they can be overcome.

Finally, even if terminal illness could be satisfactorily defined, it would not last long as a restriction on PAS. The courts below held, for example, that there are no differences between PAS and FLST. If that were true, requiring terminal illness would eventually be dropped, since there is no such requirement for FLST.

B. Competence.

Another criterion, upon which the right to PAS recognized by the courts below is contingent, is competency at the time the request for PAS is made and implemented. This criterion is also problematic. Classifying competence is difficult and sometimes impossible. In addition, the requirement raises troubling questions about PAS, since it may induce patients to choose suicide preemptively, in order to preclude losing the option through a subsequent deterioration in their mental faculties. Furthermore, the competence requirement interacts with the requirement for being terminally ill, since patients tend to lose competence as illness becomes more severe.

Although a variety of legal and medical decisions are predicated on a finding of competency, there is no uniform standard or set of procedures for making this deter-

mination.[52] In practice, such judgments typically are made by health care professionals, in consultation with family members, and may be influenced by many factors, including the purpose of the evaluation. No professional discussion yet addresses appropriate competence standards for PAS, what components of cognitive and emotional functioning should be measured, or how capable the person must be in each component (or all taken together) in order to qualify for PAS.

The seriously ill commonly have deficits in cognitive and emotional functioning which change over relatively short periods of time and correlate strongly with suicide inquiries. Many elderly patients and dying cancer patients experience delirium, a syndrome in which they are confused, unable to maintain attention, and unable to master new information.[53] Most episodes are not detected in usual care. Likewise, depression is common, serious, and often undetected and untreated.[54] Depression, delirium, and mood disorders strongly correlate with suicide. Indeed, most cancer patients now committing suicide have discernible psychiatric illness, and having such an illness corresponds strongly with risk of suicide.[55] Treatment of depression substantially alters an initial inclination to refuse life-sustaining treatment.[56] Excluding these patients from access to PAS would be essential, but that turns

[52] Paul S. Appelbaum & Thomas Grisso, *Assessing Patients' Capacities To Consent To Treatment*, 319 New Eng. J. Med. 1635-1638 (1988).

[53] J. Francis, et al., *A Prospective Study Of Delirum In Hospitalized Elderly*, 263 JAMA 1097-1101 (1990); William Brietbart, et al., *Neuropsychiatric Syndromes and Psychological Symptoms in Patients with Advanced Cancer*, 10 J. Pain Symptom Mgmt. 131-141 (1995).

[54] Brietbart et al., *supra* note 53.

[55] Breitbart, *supra* note 13.

[56] Linda Ganzini, *The Effect of Depression Treatment on Elderly Patients' Preferences for Life-Sustaining Medical Therapy*, 151 Am. J. Psychiatry 1631-1636 (1994).

out to be quite difficult. Most depression, just like most delirium, is not recognized or treated in current practice.[57] The risks of involving persons with diminished capacity in PAS are substantial. Furthermore, a narrow definition of terminal illness will yield high rates of incompetence while a broader definition will yield high rates of long survival.

Moreover, as suggested above, a special problem with a lengthy dying process is fear of the indignity associated with incompetence.[58] If the right to PAS extends only to those with contemporaneous competence, then patients with conditions likely to lead to incompetence may find it appealing to undertake preemptive suicide. This is a special risk in early dementia, when patients retain ability to understand but have failing memory. The rate of progression to cognitive disability is unpredictable. Thus dementia patients hoping to avoid the worst-case scenario may be sacrificing many comfortable and relatively capable years when they seek PAS preemptively.

C. Undue Influence—Coercion.

1. *The Context of Care.*

Proponents of a constitutional right to PAS expect the practice to be limited to persons who are acting voluntarily, without undue influence or coercion. The image is that of an independent, capable person thoughtfully evaluating his or her options, unaffected by biased third parties or other circumstances. This is so far from the experience of dying as to be fanciful. Dying persons are often very weak, prone to strong emotions, and vulnerable to the suggestions, expectations, and guidance of others. In this context, pressure or encouragement from family, friends, and caregivers may cloud or overwhelm the patient's in-

[57] S.R. Rapp, et al., *Detecting Depression In Elderly Medical Inpatients*, 56 J. Consult. Clin. Psychol. 509-513 (1988).

[58] *Supra* note 8; *supra* note 13; *see also* P.J. Van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669-674 (1991).

dependent judgment and thus amount to inappropriate coercion.[59]

The health care available to the terminally ill may be the most important factor influencing the care provided and may result in requests for PAS that could be avoided if appropriate care were available. Large variations in whether people die at home or in a hospital in various regions of the country are strongly related to hospital bed supply and regional hospice investment, and not to preferences, wealth, family presence, or other patient characteristics.[60]

2. *Financial Considerations.*

Patients nearing death are generally quite disabled and their care is costly. While hospital and physician costs decline past the age of 70, long-term care costs rise, and these are mostly borne privately.[61]

The plaintiff-patients in the cases below do not appear to have been burdened with economic difficulties. Yet, economic influences are among the most important in defining a population eligible for PAS. One-quarter of those over 65 are below 150% of the Federal poverty level, and institutional long-term care has become largely a poverty program under Medicaid.[62] As pressures increase to curtail health care expenses, hospital admissions are limited and hospitalizations are shortened. Decreasing availability and increasing expense in health care and the

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[59] H.M. Chocinov, et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185-1190 (1995).

[60] R. Pritchard, et al., *Regional Variation in the Place of Death*, 9 J. Gen Internal Med. 146a (1994); *see also* The Center for the Evaluative Clinical Sciences, Dartmouth Medical School, *The Dartmouth Atlas of Health Care* (AHA Publishing 1996).

[61] A Scitovsky, "*The High Cost of Dying Revisited*," 72 Milbank Mem. Fund. Q. Health Soc. 561-591 (1994).

[62] *Id.*; *see also* Marilyn Moon, *Medicare Now and in the Future* (1996).

uncertain impact of managed care may intensify pressure to choose PAS.

Should financial pressures be considered undue influence or not? This is the special dilemma of those who serve the frail, disabled, and poor. The AGS's concern is that PAS may become inherently coercive in a society in which supportive services and medical care are often unavailable. It would be ironic, indeed, to have a constitutional right to PAS when there is no guarantee of access to health care.

D. Suffering.

The courts below also appear to assume that the right to PAS may be reliably limited to persons who are suffering or in pain. Medical practice has no consensus on how to define or measure such a state. Most patients can be physically comfortable without sedation, and sedation can always eliminate symptoms in persons near death. This course is available at present, without any change in the law, and thus precludes a requirement that the patient must have symptoms that cannot be relieved. While some may view such treatment as undesirable, it is difficult to see why death through PAS should be considered a distinctly better (and constitutionally dictated) policy option.

E. Physician Involvement.

There is little reason to believe that physicians now have expertise in modes of killing, yet all proposals for PAS mandate physician participation. Although the counseling skills and prescription-writing privileges of physicians might at first blush suggest that their involvement in PAS is appropriate, this Court should recognize the practical difficulties this requirement imposes upon medical caregivers. There is no drug approved as safe and effective and therefore no drug legally available for PAS,[63] no in-

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[63] In a recent survey of Oregon physicians who would be eligible to prescribe under the 'Death with Dignity Act,' 50% of respondents

struction is given in medical texts,[64] and practice standards show pervasive inattention to counseling and symptom management for those near death. Physicians are usually required to inform patients of alternatives which might be advantageous. No proposal has exempted PAS, but the implications of having to broach this subject with seriously ill persons have not been considered in the discussions to date. The potential for engendering distrust and diminishing effectiveness in physician-patient encounters may justify not engaging physicians in this work. Without experience, recognizing a right to commit suicide through the assistance of physicians is clearly premature.

F. The Scope of Assistance.

The constitutional right to PAS articulated by the courts below limits the physician's aid to prescribing medications in lethal doses. Clinical experience suggests that this limit is untenable and will inevitably lead to demands for more active physician involvement in bringing about the patient's death.

If a physician were to prescribe medication in a dose which should be sufficient to cause death, the rulings below require that the patient seeking PAS actually ingest the drugs and do not provide for any further assistance by the physician. Very likely, patients will sometimes take too little of the drug, will be more resistant than expected, or might vomit and lose much of what was ingested. Determining the appropriate response to a partial overdose in the context of legal, assisted suicide would pose difficult problems for physicians, family members, or friends, since survival with brain damage and incompetence could result.

Such difficulties seem likely to lead to pressure to allow intravenous administration of lethal drugs, both because

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said they did not know what to prescribe for PAS. M.A. Lee, et al., *Legalizing Assisted Suicide - Views of Physicians in Oregon*, 334 New Eng. J. Med. 310-315 (1996).

[64] A. Carron, et al., *What is Taught About Care for the Dying in Three General Medicine Texts?*, 44 J. Am. Geriatrics Soc'y, 533 (1996).

they are more reliable and because they bring about death without apparent symptoms, such as prolonged respiratory distress, that might be difficult for family members or attendants to witness. Limiting the scope of physician assistance to the prescription of lethal drugs is thus unlikely to be sustainable. The experiences of physician assisted death in The Netherlands suggest that a progression from patient self-administration of lethal medication to physician assistance with intravenous routes is a likely consequence of allowing PAS.[65]

In summary, the criteria delimiting the boundaries of the constitutional right to PAS found by the courts below are inherently unstable, difficult or impossible to define, and probably incapable of application at the present time. Without the benefit of further experience, there simply is no way of knowing whether this society could accommodate the exercise of a constitutional right dependent on these eligibility criteria.

IV. THE COURT SHOULD VACATE THE ORDERS OF THE LOWER COURTS.

This Court should reverse the opinions of the lower courts, and decline to recognize a constitutional right to PAS for a limited class of persons at the end of life. This is clearly an issue that is not ripe for consideration by this Court now. We explicitly adopt the legal argument for this position as presented by the Project on Death in America in an *amicus* brief filed in these cases.[66]

As explained above, no jurisdiction in the United States has yet had any experience with the practice that, it is contended, should be recognized as a fundamental right. The AGS has been opposed to legalizing PAS or physician involvement in euthanasia, primarily on the grounds that

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[65] P.J. Van der Maas, et al., *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669 (1991).

[66] *See also* Robert A. Burt, *Constitutionalizing Physician-Assisted Suicide: Will Lightning Strike Thrice?*, 35 Duquesne L. Rev. 159-181 (1996).

our frail elderly patients are especially vulnerable to social coercion and that the well-being of those who are old and sick is not being carefully considered in the legislative and judicial discussion of this issue.

This is a very dynamic time with regard to care at the end of life. Only in the last few decades has living past the eighth decade become commonplace, and only recently has dying become a slow process in the setting of progressive chronic disease. New findings about what can be done with regard to relieving symptoms and supporting dying persons and their families are being reported regularly. States continue to debate both their support of the poor and their willingness to allow PAS. This is a time to enhance our understanding of how to care for dying patients, not a time to foreclose further learning by precluding innovation and evaluation.

Instead, we believe that the issue should be left to institutions more able to fashion flexible resolutions, with the benefit of further study and debate, such as state legislatures, the health care professions, and community organizations.

In this connection, we note that, should the Court agree with the Petitioners' arguments that the New York and Washington statutes do not violate the 14th Amendmen, then the 10th Amendment could provide an additional constitutional framework for reversal.[67] Since the Constitution neither delegates to the federal government the power to regulate PAS, nor prohibits its regulation by "the States, [such power is] reserved to the States respectively, or to the people." [68]

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[67] *See New York v. United States*, 505 U.S. 144, 157 (1992) ("The question is not what power the Federal Government ought to have but what powers in fact have been given by the [States and] the people." (*quoting United States v. Butler*, 297 U.S. 1, 63 (1936)); *see also Mugler v. Kansas*, 123 U.S. 623, 664 (1887).

[68] U.S. Const. amend. X; *see also U.S. Term Limits v. Thornton*, 115 S. Ct. 1842, 1876 (1995) (Thomas, J., dissenting); *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 546 (1985) ("The essence of our federal system is that within the realm of authority left open to them under the Constitution, the States must be equally free to engage in any activity that their citizens choose for the common weal, no matter how unorthodox or unnecessary anyone else —including the judiciary—deems state involvement to be.")

CONCLUSION

For the foregoing reasons, the judgments of the United States Courts of Appeals for the Second and Ninth Circuits should be reversed.

Respectfully submited,

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APPENDIX

APPENDIX

POSITION STATEMENT

Physician-Assisted Suicide and
Voluntary Active Euthanasia

AGS Ethics Committee *

BACKGROUND

The American Geriatrics Society has previously issued a statement on Voluntary Active Euthanasia (VAE). The public debate on this subject has broadened to include Physician-Assisted Suicide (PAS) and reflects the concern of many individuals about control over the terminal phase of their lives. The Society has affirmed that patients have the authority to choose among available plans of care, but their autonomy is limited when there are substantial detrimental effects on the lives of others or their choices conflict with legal or professional standards. (*See* AGS position statement, "Medical Treatment Decisions Concerning Elderly Persons"). Advocates of extending legal and professional standards to include VAE and PAS believe it is the patient's right to choose deliberately to end his or her life, under circumstances of intolerable suffering, when that individual reasonably and voluntarily prefers death to the life that confronts him or her.

DEFINITION OF TERMS

Physician-Assisted Suicide

When a physician provides either equipment or medication, or informs the patient of the most efficacious use of already available means, for the sole purpose of assisting the patient to end his or her own life.

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* Prepared by Margaret Drickamer, MD; reviewed and approved by the AGS Ethics Committee and the AGS Board of Directors, November 1994. Copies of this position statement may be obtained from the American Geriatrics Society.

Voluntary Active Euthanasia

When, at the request of the patient, a physician administers a medication or treatment, the sole intent of which is to end the patient's life.

Withholding or Withdrawing Treatment

When a medical intervention is either not given or the on-going use of the intervention is discontinued, allowing natural progression of the underlying disease state.

POSITION

1. For patients whose quality of life has become so poor as to make continued existence less preferable than death, the professional standard of care should be that of aggressive palliation, not that of intentional termination of life. It is morally acceptable for a physician to administer a medication with the intent of treating a symptom, knowing that the medication may have the unintended effect of hastening the patient's death. This approach may include the withholding or withdrawing of any medical intervention as well as the specific palliation of symptoms, even if this advances the moment of death. The patient's request for death should trigger the physician's thorough exploration and understanding of the patient's suffering and the reason the request is being made at that particular time.
2. Patients for whom these issues are relevant should be informed of two important facts: a. Profound pain can be relieved with analgesia or sedation, and b. Patients may choose to forgo any life-prolonging intervention, including artificial nutrition and hydration. Because these issues are often misunderstood, the physicians have the responsibility to inform their patients of these alternatives.
3. Laws prohibiting VAE and PAS should not be changed. In giving a patient the means to palliate his

or her symptoms, a physician may inadvertently provide the means for suicide (e.g., by prescribing necessary but potentially lethal medications). The law should differentiate between this situation and the intentional participation in the planning and execution of a suicide. Laws in many states remain very vague as to the extent to which the physician's participation is considered to be a breach of the law. The definition and legal status of PAS should be further clarified.

4. If PAS or VAE are legal in any jurisdiction, the AGS contends that the strongest protection for patients to make a choice free of coercion should be in place and that it should be illegal for professional caregivers to receive financial compensation for assisting in suicide or euthanasia.

RATIONALE FOR CONTINUED PROHIBITION

1. Historically, the fundamental goal of the doctor/patient relationship has been to comfort and to cure. To change the physician's role to one in which comfort includes the intentional termination of life is to alter this alliance and could undermine the trust between physician and patient.
2. Allowing for VAE and PAS (especially in view of the possibility for its use in Advance Directives where patients are no longer competent and their directives are subject to interpretation) opens the door for abuse of the frail, disabled, and economically disadvantaged of society.
3. It is the general consensus of the AGS that most individuals who consider PAS or VAE do so out of fear of the dying process. The vast majority of patients can be appropriately palliated (including the use of general sedation) and would choose this alternative if they had full confidence that the medical profession would do so. A thorough search for the

underlying reason for the request for death may uncover several areas amenable to potential interventions (e.g., undertreated physical symptoms, psychosocial or spiritual crisis, clinical depression, etc.).

4. Legalization of physician-assisted suicide might thwart society's resolve to expand services and resources aimed at caring for the terminally ill, dying patient.

RECOGNITION OF THE CONSEQUENCES OF CONTINUED PROHIBITION

1. By prohibiting physicians from participating in VAE or PAS, we are limiting the patient's autonomy to choose his or her mode of death. For a patient who has intractable suffering and a limited life span, who has turned down general sedation, and who wishes to avail him- or herself of the choice to plan or execute their own demise, we must withhold our professional assistance.
2. Knowing that a small number of patients will choose this alternative despite our professional nonparticipation, the AGS recognizes that its members may choose not to give professional support to the patient in this decision.

FUTURE DEBATE

The medical profession, as well as society as a whole, is continuing to address this issue. We encourage this continued debate as the physician's role in the care of the dying patient is further defined.

POSITION STATEMENT

The Care of Dying Patients: A Position Statement from the American Geriatrics Society

AGS Ethics Committee *

BACKGROUND

Dying is the final portion of the life cycle for all of us. Providing excellent, humane care to patients near the end of life, when curative means are either no longer possible or no longer desired by the patient, is an essential part of medicine. The American Geriatrics Society (AGS) recognizes that most people near the end of life desire and should be able to obtain attentive and effective care directed at relieving symptoms, maximizing comfort, and maintaining dignity and control. Providing excellent care to dying patients and their families is time consuming and requires expertise as well as compassion. Care of patients who are dying is more than just withholding burdensome treatments; it is the provision of a special form of medical care, one in which physicians can take pride and find fulfillment. Making such care regularly available will require improvements in systems for service delivery and in professional education.

DEFINITIONS

Patients Who are Dying

Within this document, people are considered to be dying when they have a progressive illness that is expected to end in death and for which there is no treatment that can substantially alter the outcome. Thus, people are dying when they have illnesses such as advanced dementia

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* Prepared by Greg A. Sachs, MD; reviewed and approved by the AGS Ethics Committee and the AGS Board of Directors, May 1994. Copies of this position statement may be obtained from the American Geriatrics Society.

or severe congestive heart failure, in addition to illnesses more routinely recognized as terminal, such as advanced cancer. Care of dying patients also encompasses patients who have elected to forgo available treatments that might forestall death, such as dialysis for end stage renal disease.

Palliative Care

Within this document, palliative care, also referred to as comfort care, refers to care directed toward the quality of life of patients who are dying, including the relief of pain and other symptoms, attention to the psychological and spiritual needs of the patient, and providing support for the dying patient's family.

PATIENT CARE ISSUES

Position 1

The care of the dying patient, like all medical care, should be guided by the values and preferences of the individual patient.

Rationale

Optimal medical care of all patients, not just those who are dying, rests on frank and sensitive communication between patients and physicians. For dying patients, this ordinarily entails recognition and discussion of the facts surrounding prognosis and the likely course with a palliative plan of care. The conversations throughout must continue to elicit and respond to the patient's needs. When the patient loses decision-making capacity, care should be guided by these previous conversations as well as by written advance directives, if available.

Position 2

Palliative care of dying patients is an interdisciplinary undertaking that attends to the needs of both patient and family.

Rationale

In caring for dying patients, physicians must themselves develop a broad array of knowledge and skills and an attentiveness to comprehensive care. In addition, whether or not the patient is enrolled in a formal hospice program, physicians most often should function as members of a team. The team may include nurses, social workers, homemakers, home health aides, physical therapists, chaplains, volunteers, and the patient's family. Each team member contributes the special knowledge and the skills of his or her discipline to help meet the needs of dying patients. Together, team members provide care for the patient and assist the family in coping with the patient's dying and death. Family members (with "family" defined by the individual patient) usually play a critical role in both providing care for dying patients and in making decisions for dying patients who have lost decision-making capacity. Providing support for the patient's family, including a period after the patient dies, is an important aspect of the palliative care of dying patients.

Position 3.

Care for dying patients should focus on the relief of symptoms, not limited to pain, and should be addressed by both pharmacologic and nonpharmacologic means.

Rationale

Pain, anxiety, depression, dyspnea, constipation, and other symptoms can all be significantly ameliorated, if not eliminated, in the vast majority of dying patients, provided we employ fully our pharmacologic armamentarium and appropriate nonpharmacologic interventions. Symptoms should be treated vigorously, even if the unintended effect of these efforts is the hastening of death. Though not medical symptoms, dignity and control are central issues for many dying patients.

HEALTH CARE DELIVERY ISSUES

Position 4

Dying patients should be guaranteed access to comprehensive, interdisciplinary palliative care across the spectrum of care settings as part of any federal or state health care reform plan, without care being conditioned on the financial status of the patient.

Rationale

Palliative care is often provided most appropriately in the patient's own home, a setting where reimbursement is inadequate under many existing insurance plans. Dying patients should be able to receive palliative care in the home, the hospital, and the nursing home, depending on the needs and preferences of the patient, without a disruption in the continuity of the patient's care.

Position 5

Reimbursement policies should be modified to enhance the availability of palliative care.

Rationale

Patients and families are presently faced with major financial obstacles to choosing palliative care, while payment for continued highly technological, acute care (e.g., dialysis, ventilator care, etc.) is readily available. Physician reimbursement should also be modified to promote palliative care. Like other forms of primary care, palliative care is time consuming, does not involve highly reimbursed procedures, and requires substantial counseling of patients and families.

Position 6

Administrative and regulatory burdens that may serve as barriers to palliative care should be reduced.

Rationale

Currently, hospices providing care for dying patients face special administrative burdens in addition to the usual paperwork facing all health care institutions. Requirements regarding availability of family and a home for caregiving regularly prevent some patients from receiving palliative care through hospices. Uncertain or unavailable estimates of prognosis also may serve inappropriately to exclude patients in need of palliative care services. Regulations intended to promote adequate nutrition for nursing home residents and laws intended to prevent assisted suicide and euthanasia should be written or revised so that these issues are not confused with proper palliative care decisions and treatment.

EDUCATION ISSUES

Position 7

Physicians, as well as other health care professionals, at all levels of training should receive concrete, insightful, and culturally sensitive instruction in the optimal care of dying patients.

Rationale

Medical students and physicians in training in the United States today rarely receive specific and in-depth instruction on the care of dying patients. This instruction should address attitudes toward and reactions to death and care of the dying, symptom management (especially pain control and adequate use of narcotic analgesics), and communication skills. The importance of knowledge about the care of dying patients should be reinforced by evaluating it on board exams and other specialty certification exams.

Position 8

The public, including our patients and our colleagues, needs to be educated regarding the availability of pallia-

tive care as an important and desirable option for dying patients.

Rationale

It is the position of AGS that this kind of educational effort would benefit many by dispelling the notion that the only options available to dying patients are continued futile therapy in a medical setting or turning to assisted suicide or euthanasia (see related AGS position statement).

RESEARCH ISSUES

Position 9

Adequate funding for research on the optimal care of dying patients should be provided.

Rationale

Much of the information base needed to inform patients and physicians regarding optimal care of dying patients does not yet exist. Studies documenting the outcomes of various types of care plans, medications, and treatment settings, especially ones focused on the experience of the dying patient, should take place. Although traditional biomedical research on symptom relief is needed, much of what is already known about symptom relief is not implemented effectively because of professional ethical concerns about aggressive symptom management and institutional barriers to the provision of palliative care. Research on these matters, including educational approaches and interventions to promote palliative care, is needed.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF THE STATE OF NEW YORK, *et al.*

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*

Respondents.

On Writ of Certiorari to the U.S. Court of Appeals for the Second Circuit

---

STATE OF WASHINGTON, *et al.*

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*

Respondents.

On Writ of Certiorari to the U.S. Court of Appeals for the Ninth Circuit

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BRIEF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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42 pp

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QUESTIONS PRESENTED

(1) Is there a Fourteenth Amendment substantive due process right to obtain a physician's assistance in committing suicide?

(2) Are patients who refuse or withdraw consent to life-sustaining treatment similarly situated to patients who request that a physician prescribe or administer a lethal dose of medication?

(3) Does the state have a sufficiently important interest in prohibiting the consensual killing of patients by physicians to outweigh any purported right to assistance in suicide?

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

INTEREST OF THE AMICUS CURIAE 1

SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. THE DUE PROCESS CLAUSE DOES NOT GUARANTEE A RIGHT TO OBTAIN A PHYSICIAN'S ASSISTANCE IN COMMITTING SUICIDE 4

A. The Washington Statute Bans Homicide, Not "Hastening One's Death". 4

B. The Court Should Not Create A New "Right" To Assisted Suicide That Lacks Any Basis In The Text Of The Constitution Or The History And Tradition Of Our Nation 6

C. This Court's Decisions In *Casey* And *Cruzan* Do Not Protect Consensual Killing 10

1. *Casey* 10

2. *Cruzan* 12

TABLE OF CONTENTS—Continued

Page

II. THE EQUAL PROTECTION CLAUSE DOES NOT GUARANTEE THE RIGHT TO ASSISTANCE IN SUICIDE 14

A. The Law Regarding Assisted Suicide And Discontinuation Of Treatment Applies Equally To All. 14

B. Assisted Suicide Is Morally Distinguishable From Forgoing Life-Sustaining Treatment And Pain Management, Both Of Which May Hasten Death. 16

1. Discontinuation of Treatment and Hastening Death 16

2. Pain Management and Hastening Death. 17

III. THE GOVERNMENT HAS A PARAMOUNT INTEREST IN PREVENTING THE KILLING OF HUMAN BEINGS THAT (1) OUTWEIGHS ANY PURPORTED LIBERTY INTEREST IN RECEIVING AID FROM A PHYSICIAN TO KILL ONESELF, AND (2) JUSTIFIES TREATING ASSISTED SUICIDE DIFFERENTLY FROM THE WITHDRAWAL OF LIFE-SUSTAINING TREATMENT 19

A. Preserving Life. 19

TABLE OF CONTENTS—Continued

Page

B. Preventing Suicide. 22

C. Protecting The Integrity Of The Medical Profession, Especially In A Managed Care Environment. 22

D. Preventing Abuse. 25

CONCLUSION 27

APPENDIX A 1a

APPENDIX B 3a

TABLE OF AUTHORITIES

Page

Cases

Bellotti v. Baird, 433 U.S. 622 (1979) 6

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Page

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Page

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Page

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TABLE OF AUTHORITIES—CONTINUED

Page

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BRIEF OF THE CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS*

INTEREST OF THE AMICUS CURIAE

The Catholic Health Association of the United States ("CHA") represents over 1200 Catholic sponsored health care facilities and organizations that serve millions of people each year.

Catholic health care organizations understand their mission to be far more than simply the delivery of a social good. "Catholic sponsored health ministry, like the church itself, must not only proclaim the gospel but commit to transform the social order according to gospel norms" of love and justice. National Coalition on Catholic Health Ministry, *Catholic Health Ministry in Transition* 4 (1995). This ministry is rooted in and informed by a deeply held commitment to promote and defend human life and human dignity.

CHA's interest in this case stems from its concern for the need to protect vulnerable persons; to insure appropriate care for dying persons; to preserve the integrity of the health care profession; to strengthen the bonds of community; and also to preserve the integrity of Catholic health ministry.

A body of moral principles developed over centuries informs Catholic teaching on health care matters. These moral principles likewise inform the National Conference of Catholic Bishops' *Ethical and Religious Directives for Catholic Health Care Services* (1995) ("*Directives*"), which provide guidance to Catholic health professionals on a range of economic, technological, social and moral challenges. For instance, Catholic health care is required to support patients

* Consents to the filing of this brief have been lodged with the clerk.

and their families who must face the reality of death. *Directives* at 21.

Furthermore, the *Directives* guide Catholic health ministry in its advocacy efforts:

> In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: * * * the elderly; [and] those with incurable diseases * * *. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons.

Id. at 7.

Assisted suicide offends the most basic moral precepts of our culture and, in particular, poses a grave danger to those "at the margins of our society." In fulfilment of its mission, the *amicus* urges this Court to reverse the Courts of Appeals.

SUMMARY OF ARGUMENT

The Ninth Circuit partial *en banc* opinion in *Compassion in Dying v. Washington* (Wash. Pet. App. A-1 to A-117), positing a substantive due process right to physician-assisted suicide, is based on two fundamental misconceptions: first, that this Court's abortion jurisprudence stands for the proposition that any "private" or "intimate" decision by a citizen is entitled to protection under the Due Process Clause; and second, that an instruction to a physician to withdraw life-sustaining treatment, which this Court assumed to merit constitutional protection in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), is equivalent to a request for a physician's assistance in suicide.

The Second Circuit's opinion in *Quill v. Vacco* (N.Y. Pet. App. 1a-62a), likewise erroneously equates a person's

negative right to refuse unwanted treatment with a positive right to be assisted in suicide, holding that New York's permission of the former and prohibition of the latter violates the Equal Protection Clause. The court could see no rational basis for making such a distinction.

Nothing in the Constitution or this Court's jurisprudence entitles citizens to request that a physician prescribe or administer the means to kill. The States of Washington and New York have the duty to protect the lives of their citizens from the consequences of legalized assisted suicide. Similarly, these states have the obligation to protect the fiduciary relationship between doctor and patient, upon which the integrity of the medical profession depends. Once health care professionals are permitted to "assist" people in killing themselves, our society's rationally constructed bright line prohibiting private killing will be obliterated.

ARGUMENT

The courts below seek to create a new constitutional right to assisted suicide based primarily on their fallacious equating of assisted suicide with the withdrawal of treatment. This fundamental error is at odds with our legal and cultural tradition.

As a starting point, we look to the example of Joseph Cardinal Bernardin, Archbishop of Chicago, who announced in October 1996 that he had decided not to continue chemotherapy for his cancer. S. Kloehn, "Bernardin Ends Cancer Care/Chemotherapy Hasn't Reduced Tumor Size," Chi. Trib., Oct. 18, 1996, at 1. In his letter to this Court, Cardinal Bernardin states, "I know from my own experience that patients often face difficult and deeply personal decisions about their care. However, I also know that even a person who decides to forgo treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention." App., *infra*, 1a. Where life-sustaining interventions are deemed ineffective or

disproportionately burdensome, even in the case of a person on a ventilator, the intervention may be removed. Whether deciding to discontinue chemotherapy or to remove a ventilator, the absence of an intent to kill distinguishes these acts from one in which a person intends to take his own life. Such an act is suicide. Facilitating such an act is assisted suicide.

I. THE DUE PROCESS CLAUSE DOES NOT GUARANTEE A RIGHT TO OBTAIN A PHYSICIAN'S ASSISTANCE IN COMMITTING SUICIDE.

In a sweeping act of positive lawmaking, the Ninth Circuit attempts to create a new substantive due process right to assisted suicide. This Court should not endorse such a dramatic departure from its precedent and from the Nation's legal and moral traditions.

A. The Washington Statute Bans Homicide, Not "Hastening One's Death."

Suicide is "[t]he act of killing oneself intentionally." *Webster's II: New Riverside Dictionary* (1984). Catholic teaching has consistently recognized the difference between killing oneself (suicide) and withholding or withdrawing disproportionate means to sustain life.[1]

However, the Ninth Circuit asks not whether there is a right to be assisted in "killing oneself intentionally," but whether there is a liberty interest in "determining the time and manner of" or "hastening one's death." Wash. Pet. App. A-29. The court's oblique declaration of the constitutional "right" it creates allows it to sweep into the discussion "a whole range of acts that are generally not considered to

[1] "Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden * * *." *Directives* at 22-23.

constitute 'suicide[]' [including] * * * the act of refusing or terminating unwanted medical treatment." *Id.* Indeed, in a total subversion of the English language, the court states that it has "serious doubts that the terms 'suicide' and 'assisted suicide' are appropriate legal descriptions of the specific conduct at issue here." *Id.*

The court's use of words is more than mere semantics. The newly proposed right is quite broad. There is no coherent way to limit a purported right to "assisted suicide" to terminally ill people or to competent people who can communicate. Once the Court affords terminally ill citizens the "right" to have a physician assist them in suicide, it will have to afford such a right at least to all competent adults for, according to the Ninth Circuit, the right is grounded not in the terminal illness, but in the right to determine the time and manner of one's death. Moreover, there is nothing to limit this right to patient-administered medication; the lower courts' reasoning would appear to apply just as readily to those seeking euthanasia (*i.e.*, physician-administered lethal medication). Of course, the Ninth Circuit dismisses this fundamental concern, "consider[ing] it less important who administers the medication than who determines whether the terminally ill person's life shall end." Wash. Pet. App. A-100 to A-101.

Once all competent adults have such a right, the right would have to be extended to incompetent adults, for incompetent persons do not lose their constitutional freedoms simply due to their incompetence. *See* Wash. Pet. App. A-159 (Beezer, J., dissenting). The only issue would be whether and how a surrogate can act for an incompetent person. *E.g.*, *Cruzan*, *supra*. Once incompetent people have the right to assisted suicide (whether or not they are terminally ill), advocates for mature or emancipated minors, and for the legal representatives of minors would urge the extension of the right to them as well. *Cf. Planned Parenthood v. Casey*, 505 U.S. 833, 970-71 (1992); *City of Akron*

v. Akron Center for Reproductive Health, 462 U.S. 416 (1983); *Bellotti v. Baird*, 443 U.S. 622 (1979).

In addition, once this Court recognizes a Substantive Due Process right of physician-assisted suicide, even for healthy adults, it will face the compelling argument of those who do not need a physician's help to commit suicide, but only wish the help of a friend or trusted family member. The purported right to assisted suicide is based on the belief that the law may not prevent a person from ending his own life, and thus that a state may not interfere with the efforts of those who would assist in such an endeavor. There is no implicit limitation in such a right to the assistance of physicians; in theory, a person entitled to "hasten their death" should be able to accept the help of anyone. At this point, assisted suicide is no longer a clinical event occurring in a health care setting; it is nothing more than state-sanctioned killing by private agreement.

B. The Court Should Not Create A New "Right" To Assisted Suicide That Lacks Any Basis In The Text Of The Constitution Or The History And Tradition Of Our Nation.

The Ninth Circuit begins (Wash. Pet. App. A-31 to A-32) by dutifully reciting the standard expressed in what it calls this Court's "highly controversial" opinion in *Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986) (citations omitted):

> Striving to assure itself and the public that announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values on the States and the Federal Government, the Court has sought to identify the nature of the rights qualifying for heightened judicial protection. In *Palko v. Connecticut*, it was said that this category includes those fundamental liberties that are "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [they] were sacrificed." A different description of fundamental liberties appeared in *Moore v. East Cleveland*, where they are characterized as those liberties that are "deeply rooted in this Nation's history and tradition."

Unfortunately, the Court of Appeals ignores this standard, all but disregarding the long history and tradition in this country of prohibiting consensual killing. Indeed, the court proceeds to survey "current societal attitudes," citing polls showing public support for "the prerogative [of patients] to accelerate their death by refusing or terminating treatment" and for assisted suicide and euthanasia. Wash. Pet. App. A-48. Relying on its understanding of "our unwritten history" and its own knowledge, the court concludes that suicide and assisted suicide are actually accepted practices in society, justifying enshrining them in the pantheon of constitutionally protected activities which may not be proscribed by legislation. *See id.* at A-51 to A-52.

An accurate reading of the American legal tradition reveals something much different. It demonstrates a consistency between our society's historical rejection of assisted suicide and Catholic teaching. Moreover, Church teaching has been influential in shaping the societal views and practices which inform this Court's due process analysis.[2]

From the earliest times, the Church has condemned

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[2] Catholic teaching has historically been a major force in the development of Western thought. R.J. Araujo, "Thomas Aquinas: Prudence, Justice, and the Law," 40 Loy. L. Rev. 897, 913-915, 921 (1995); G. N. Herlitz, "The Meaning of the Term 'Prima Facie,'" 55 La. L. Rev. 391, 391 n.5 (1994). On end-of-life issues, courts have referred freely to historical Catholic teachings in their examination of this society's moral traditions. *E.g.*, Wash. Pet. App. A-131 to A-134 (Beezer, J., dissenting); *In re Quinlan*, 355 A.2d 647, 659-60 (N.J.), *cert. denied* 429 U.S. 922 (1976).

suicide.[3] Two figures in the Church's history stand out in this regard. St. Augustine of Hippo (354-430) articulated the principles on which Christianity condemned suicide by arguing that the prohibition against killing applies to all persons, including oneself. St. Augustine, *City of God*, Book I, ch 20. Building upon that foundation, St. Thomas Aquinas (c.1225-1273) further explained the reasoning behind the prohibition, arguing that suicide is contrary to the natural inclination that persons love themselves, that suicide injures the community, and that God alone has the power over life and death. St. Thomas Aquinas, *Summa Theologica II-II*, Q. 64, art. 5. Significantly, Aquinas also argued that suicide is an offense because it is an act of injustice against the community.

In this century, the Second Vatican Council reiterated the Church's powerful opposition to suicide:

> The varieties of crime [against the human person] are numerous: all offenses against life itself, such as murder, genocide, abortion, euthanasia and wilful *suicide* * * * all these and the like are criminal: they poison civilization; and they debase the perpetrators more than the victims and militate against the honor of the creator.

"Pastoral Constitution on the Church in the Modern World" (*Gaudium et spes*), *Vatican Council II*, at 926 (A. Flannery, ed. 1992) (emphasis added).

More recently, the Vatican reiterated the Church's opposition to suicide:

> Intentionally causing one's own death, or suicide, is therefore equally as wrong as murder; such an action on

[3] *E.g.*, the Council of Arles (452), the Council of Braga (563), the Antisidor Council (590) and the Synod of Nimes (1274). T. Marzen, M. O'Dowd, D. Crone & T. Balch, "Suicide: A Constitutional Right?" 24 Duquesne L. Rev. 1, 57, 60 (1985).

> the part of a person is to be considered as a rejection of God's sovereignty and loving plan.

Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 7 (1980). *See also Directives* at 21 ("Suicide and euthanasia are never morally acceptable options").

Most recently, the *Catechism of the Catholic Church* emphasizes the broad social consequences of killing oneself. Suicide "offends love of neighbor because it unjustly breaks the ties of solidarity with family, nation, and other human societies to which we continue to have obligations." United States Catholic Conference, *Catechism of the Catholic Church* § 2281, at 550 (1994). In sum, the Catholic tradition's aversion to suicide is so strong that the American Bishops insist that those associated with the Catholic health care ministry neither condone nor participate in assisted suicide. *Directives* at 23.

Our own legal tradition has also consistently condemned suicide, and thus assisted suicide. Henry de Bracton's 1220 treatise and Sir Edward Coke's 1644 treatise, *Third Institute of the Law of England,* identified the common law crime of suicide and its severe property penalties. *See* T. Marzen, M. O'Dowd, D. Crone & T. Balch, Suicide: A Constitutional Right?" 24 Duquesne L. Rev. 1, 57, 60 (1985). In *Hales v. Petit*, 75 Eng. Rep. 387 (1561-62), the English Court applied sanctions against suicide. In the United States, *Massachusetts Commonwealth v. Bowen*, 13 Mass. 356 (1816), illustrates the early American common law prohibition against assisted suicide. The fact that states later abolished criminal penalties for unilateral suicide does not reflect societal approval of these acts. "These changes occurred, rather, because punishment was seen as unfair to innocent relatives of the suicide and because those who committed or who attempted to commit the act were thought to be prompted by mental illness." Y. Kamisar, "Are Laws Against Assisted Suicide Unconstitutional?" 23 *Hastings*

Center Report 32, 41 (1993). Indeed, the common law, and in many instances state statutes, prohibited suicide and assisted suicide both at the time of the Revolution and at the time the Fourteenth Amendment was ratified. *See* Wash. Pet. App. A-44 to A-46; *Cruzan*, 497 U.S. at 294 (Scalia, J., concurring), citing Marzen, *et al., supra.* In fact, notwithstanding the Ninth Circuit's research into popular opinion, all but one state today prohibits assisted suicide. *See* Wash. Pet. App. A-48 to A-49.

Because our moral tradition and our law has so uniformly condemned these practices, it is simply inaccurate to say that the right to assist in committing a suicide is a "liberty" that is "deeply rooted in this Nation's history and tradition," or that is "implicit in the concept of ordered liberty." Indeed, it is our proud history to have prohibited such dangerous conduct.

C. This Court's Decisions In *Casey* And *Cruzan* Do Not Protect Consensual Killing Or Assisted Suicide.

The Ninth Circuit relies on *Casey* and *Cruzan* for the unsupportable proposition that there is a liberty interest in "hastening death" which the state may not burden. Neither *Casey* nor *Cruzan*, however, can support the creation of this expansive right. Although in both cases this Court applied a balancing test to state restrictions on actual or assumed liberty interests (the same test the Ninth Circuit purports to apply), the finding of liberty interests in *Casey* and *Cruzan* was itself subject to the larger principles enunciated in *Bowers* and prior cases.

1. *Casey*

According to the Ninth Circuit, *Planned Parenthood v. Casey* requires the conclusion that there is a liberty interest in assisted suicide because "the decision how and when to die is one of 'the most intimate and personal choices a person may make in a lifetime,' a choice 'central to personal dignity

and autonomy.'" Wash. Pet. App. A-57 (quoting *Casey*).

The language in *Casey* about highly personal and intimate decisions cannot be taken out of context to support the awesome breadth of the Ninth Circuit's pronouncement.[4] The Court did not say that *any* intimate decision of importance to the individual ought to be treated as a liberty interest. Many such decisions not only lack constitutional protection, but are in fact proscribed by law:

> Those adjectives might be applied, for example, to homosexual sodomy, polygamy, adult incest, *and suicide*, all of which are equally 'intimate' and 'deep[ly] personal' decisions involving 'personal autonomy and bodily integrity,' and all of which can constitutionally be proscribed because it is our unquestionable constitutional tradition that they are proscribable.

Casey, 505 U.S. at 984 (Scalia, J.) (emphasis added). Suicide—and *a fortiori*, assisted suicide—have long been proscribed, and are not entitled to constitutional protection regardless of their "intimate" or "personal" nature. *Cf.* Bernardin, infra, 1a-2a (assisted suicide not merely a personal matter because it harms society).

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[4] The Court's decision in *Casey* was heavily influenced by the doctrine of stare decisis, leading certain members of the Court to recognize a liberty interest in having an abortion in deference to *Roe v. Wade*, 410 U.S. 113 (1973), even if they might not have done so in the first instance. 505 U.S. at 853. Thus, the Court set the case apart: "Abortion is a unique act * * *. [T]he liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." *Id.* "[O]ne could classify *Roe [v. Wade]* as *sui generis*." *Id.* at 857 (plurality). *Accord id.* at 952 (Rehnquist, C.J., concurring and dissenting). Indeed, "because *Roe*'s scope is confined by the fact of its concern with postconception *potential* life, * * * any error in *Roe* is unlikely to have serious ramifications in future cases." *Id.* at 859 (emphasis added). The abortion precedents are simply not applicable in other contexts, and cannot provide a basis for extending "privacy" or "liberty" to assisted suicide.

2. *Cruzan*

The Ninth Circuit next cites this Court's decision in *Cruzan* to support its creation of a constitutional right to "hasten death." Wash. Pet. App. A-62. In *Cruzan*, the Court assumed that a patient would have the right to refuse or terminate life-sustaining medical treatment, but held that the state had the right to insist on strict safeguards in cases involving incompetent persons. Accordingly, the Court upheld Missouri's "clear and convincing" standard for proof of an incompetent individual's wishes. 497 U.S. at 284.

Cruzan did not recognize any generalized "right to die," let alone a right to assisted suicide. On the contrary, the Court explicitly noted with approval the fact that assisted suicide was *illegal* under state law:

> States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, *the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide*.

497 U.S. at 280 (emphasis added).

Despite this clear language and the expressly narrow grounds of this Court's decision, the Ninth Circuit used *Cruzan* as a springboard to an expansive "right" heretofore unknown to the law:

> *Cruzan*, by recognizing a liberty interest that includes the refusal of artificial provision of life-sustaining food and water, *necessarily* recognizes a liberty interest in hastening one's own death.

Wash. Pet. App. A-62 (emphasis added). To appreciate the magnitude of the lower court's illogical leap from the actual *Cruzan* holding, the Court need look no further than at how the *Cruzan* Court reached its decision.

The Court began with a discussion of the doctrine of

informed consent at common law. 497 U.S. at 269 ("[the] notion of bodily integrity has been embodied in the requirement that informed consent is generally required for medical treatment"). As the Court noted, "[t]he logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 270. *See also id.* at 277 ("As these [state law] cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment"). This was not anything so broad as a right to "privacy,"[5] but rather the right to be free of compelled surgical intrusions. *E.g.*, *Cruzan*, 497 U.S. at 287-289 (O'Connor, J., concurring):

> Requiring a competent adult to endure [forced medical treatment] against her will burdens the patient's liberty, dignity, and freedom to determine the course of her own treatment. Accordingly, the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.

The right assumed to exist in *Cruzan* is thus firmly rooted in the jurisprudence of battery, not some inchoate right to control human destiny in all respects. *Cruzan* does not govern this case.

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[5] *E.g.*, *Cruzan*, 497 U.S. at 279 n.7:
Although many state courts have held that a right to refuse treatment is encompassed by a generalized constitutional, right of privacy, we have never so held. We believe this issue is more properly analyzed in terms of a Fourteenth Amendment liberty interest. See *Bowers v. Hardwick*, 478 U.S. 186, 194-195 (1986).

II. THE EQUAL PROTECTION CLAUSE DOES NOT GUARANTEE THE RIGHT TO ASSISTANCE IN SUICIDE.

As the Second Circuit observes, the Equal Protection Clause "simply requires the states to treat in a similar manner all individuals who are similarly situated." N.Y. Pet. App. 20a. "The general rule, then, is that state legislation carries a presumption of validity if the statutory classification is 'rationally related to a legitimate state interest.'" *Id.* at 21a, quoting *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985).

The Second Circuit struck New York's statutes criminalizing assisted suicide under the Equal Protection Clause on the ground that:

> New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths [and] the distinctions made by New York law with regard to such persons do not further any legitimate state purpose.

N.Y. Pet. App. 24a. The court acknowledged that the statute fell "within the category of social welfare legislation and [was] therefore subject to rational basis scrutiny upon judicial review" but could see no "legitimate state purpose" to distinguish between persons who withhold or withdraw their consent for life-sustaining treatment and persons who wish to have physicians assist them in killing themselves. *Id.* at 24a-25a.

A. The Law Regarding Assisted Suicide And Discontinuation Of Treatment Applies Equally To All.

The Second Circuit errs in subjecting New York's legislation to judicial review because New York does not discriminate between "similarly situated" individuals at all. In New York, as almost everywhere, a patient has the right to refuse or discontinue unwanted medical treatment. *See*

N.Y. Pub. Health Law § 2892. As noted in Section I, *supra*, this right derives from the doctrine of informed consent, and is grounded in the Constitution's protection of bodily integrity. *See Cruzan*, 497 U.S. at 277. Arguably, a physician who does not respect this right is guilty of at least a civil battery. *Id.* at 269.

On the other hand, in New York, as almost everywhere, it is illegal to aid or abet a suicide, or to kill another person, even where the individuals involved are a physician and a patient. N.Y. Penal Law §§ 125.15(3), 120.30. *See also Cruzan*, 497 U.S. at 290-291 nn.2-4 (O'Connor, J., concurring) (collecting various state laws). The Court of Appeals equates revocation of consent to life-sustaining treatment and assisted suicide because they both result in the death of the patient. *See Cruzan*, 497 U.S. at 280. "But constitutional law does not work that way." *Cruzan*, 497 U.S. at 286.[6]

For one thing, patients in each example seek to employ vastly different means to their respective ends, and it is those means which New York treats differently. As did the Ninth Circuit, the Second Circuit ignores this, adopting instead the imprecise and misleading descriptor that both patients are "hastening their deaths." N.Y. Pet. App. 29a-30a. One can equate virtually any two situations by defining the terms broadly enough, but that is not the purpose of the Equal Protection Clause. *E.g.*, *Kelley v. Johnson*, 425 U.S. 238 (1976) (right of bodily autonomy does not include right to control personal appearance at the workplace).

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[6] The assertion that different courses of conduct are equivalent simply because they cause the same result is absurd. Accidents, self defense and murder all cause deaths. Abortion and feticide both kill fetuses. Illegal drugs and alcohol both cause intoxication. The law treats all of these matters differently because they all involve different conduct. Of course, the source of the Ninth Circuit's confusion is that it improperly identifies the effect (*i.e.*, causing death) as the right assumed in *Cruzan* instead of the means (*i.e.*, withdrawal of life-sustaining treatment). *Cf.* Bernardin, App., *infra*, 1a-2a.

Indeed, New York's ban on assisted suicide is a neutral, generally applicable body of law that proscribes conduct; it does not apply unequally to different classes of people. New York does not purport to prohibit "hastening one's own death." New York prohibits aiding and abetting a suicide.

It is true that under New York's scheme some people end up with more control over the precise timing of their deaths than others, but that is not the fault of the law. It is simply due to the biological fact that certain people will die without medical intervention while others will not. The important point for Equal Protection purposes, however, is that both classes of people have precisely the same legal rights and are subject to precisely the same legal prohibitions: the right to refuse or withdraw treatment (regardless of the expected outcome), and the prohibition against aiding and abetting suicide. The fact that results arising from the exercise of the right and from the impact of the prohibition vary with the individual is not only permissible, it is to be expected in any society made up of unique individuals. *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (Equal Protection Clause does not guarantee identical outcomes, just equal treatment under law).

B. Assisted Suicide Is Morally Distinguishable From Forgoing Life-Sustaining Treatment And Pain Management, Both Of Which May Hasten Death.

1. Discontinuation of Treatment and Hastening Death.

In Catholic teaching, assisted suicide is nothing less than killing. The dignity of the human person is not promoted through acts which destroy life. There is thus an important distinction between suicide and the choice to forgo disproportionate life-sustaining treatment.

Cardinal Bernardin is "at the end of [his] earthly life." App., *infra*, 1a. His decision to discontinue chemotherapy will probably hasten his death. Similarly, a decision to forgo

disproportionate life-sustaining treatment (though the person may die) does not necessarily entail an intention to kill. Both decisions are consistent with Church teaching on due proportion in the use of remedies. Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 11-12 (1980). As noted in the *Directives* (at 21):

> We have a duty to preserve our life and to use it for the glory of God, but the duty to preserve life is not absolute, for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome.

2. Pain Management And Hastening Death.

In the course of treatment, patients often require increasing doses of medications like morphine to control their pain. In seeking to control pain, the prescribing physician runs the risk of depressing respiration, and thus while trying to manage pain, hastening death. A. Hardie, "Morphine Drip has Little Opposition," *Atlanta Const.*, Mar. 8, 1995, at C3; L. Lamberg, "Treating Depression in Medical Conditions May Improve Quality of Life," 276 JAMA 857 (1996). In such circumstances, there is no intention to kill the patient. Death is not the object of the act. Nor is "hastening death" the *means* used to relieve pain, even though death may be forseen.

The practice of prescribing effective pain relief that may, at the same time, hasten death as a forseen yet unintended consequence is supported by both the medical profession and Catholic teaching:

> Medications capable of alleviating or suppressing pain may be given to a dying person, even if this therapy may indirectly shorten the person's life so long as the intent is not to hasten death.

Directives at 23; *cf. Declaration on Euthanasia*, *supra*, at 7-9; Pius XII, *Address* of 24 February 1957: *Acta Apostolicae Sedis* 49, at 147. *See also* Kathleen M. Foley,

"Pain, Physician-assisted Suicide, and Euthanasia," 4 *Pain Forum* 163, 164 (1995).

This analysis is consistent with the principle of double effect, Thomas O'Donnell, *Medicine and Christian Morality* 29 (1976), as understood in both the Catholic moral tradition and the medical profession. *E.g.*, D. Gianelli, "Assisted Suicide or Pain Relief?" *Am. Med. News*, July 1, 1996, at 3; D. Wintersheimer, "The Role of Courts in Terminating Nutrition and Hydration for Incompetent Patients," 10 *Issues in L. & Med.* 453, 457 (1995). Moreover, it points out the fallacious reasoning of the Ninth Circuit, which concedes its lack of appreciation for the concept:

> More specifically, we see little, if any, difference for constitutional or ethical purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the known effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. * * * To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other.

Wash. Pet. App. A-82.

Of course, in the case of palliative care and forgoing disproportionate life-sustaining treatment "the intended result" is *not* death, but the alleviation of pain or burden. The fact that killing and withdrawal of treatment might both "hasten death" does not render them morally equivalent.

Accordingly, those who forgo life-sustaining medical interventions and those who seek a fatal dose of medication from a physician are not "similarly situated." Physicians respecting the right of a patient to refuse life-sustaining treatment are not similarly situated to physicians who comply with a patient's request for the means to accomplish a fatal

drug overdose. Statutory schemes permitting the former and prohibiting the latter simply reflect society's respect for bodily integrity and its condemnation of homicide. As such, they are not subject to judicial review under the Equal Protection Clause.

III. THE GOVERNMENT HAS A PARAMOUNT INTEREST IN PREVENTING THE KILLING OF HUMAN BEINGS THAT (1) OUTWEIGHS ANY PURPORTED LIBERTY INTEREST IN RECEIVING AID FROM A PHYSICIAN TO KILL ONESELF, AND (2) JUSTIFIES TREATING ASSISTED SUICIDE DIFFERENTLY FROM THE WITHDRAWAL OF LIFE-SUSTAINING TREATMENT.

Even if the Court were to find that there is a liberty interest in "hastening one's death" by assisted suicide, or that those seeking to "hasten death" by forgoing life-sustaining treatment and by assisted suicide are "similarly situated," the government may still prohibit assisted suicide if it can demonstrate a sufficient interest in doing so. For Equal Protection purposes, the state need only show a rational basis for the legislation. N.Y. Pet. App. 21a. For Due Process purposes, a balancing test may be employed. *E.g.*, Wash. Pet. App. A-22. In either case, the Washington and New York statutes should be upheld because those states have a compelling interest in prohibiting assisted suicide, sufficient to outweigh any purported liberty interest in private consensual killing, and sufficient to justify distinguishing between revocation of consent to life-sustaining treatment and receiving physician assistance in killing oneself.

A. Preserving Life.

The Ninth Circuit accurately describes the state's unqualified interest in preserving life:

> [T]he State may assert an unqualified interest in preserving life in general. As the Court said in *Cruzan*,

> "we think a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life * * *." *Cruzan*, 497 U.S. at 282. Thus the state may assert its interest in preserving life in all cases, including those of terminally ill, competent adults who wish to hasten their deaths.

Wash. Pet. App. A-65. Unfortunately, the court then ignores its own observation, concluding that Washington does *not* have an interest in preserving life simply because, like most states, it permits patients to refuse or revoke consent for life-sustaining medical treatment. *Id.* The Second Circuit employs essentially the same argument. *See* N.Y. Pet. App. 32a.

This approach is flawed in two ways. First, it simply begs the question of whether forgoing life-sustaining treatment can be equated with aiding a person in committing suicide. As demonstrated above, it cannot. Washington and New York do not value life any less simply because their citizens have the right to be free from non-consensual touchings. *See* RCW 70.122.010 (basing right to withdraw treatment on the right to individual autonomy); N.Y. Pub. Health Law § 2892 (codifying state common law to same effect).

Second, after paying lip service to the principle that "'a state may properly decline to make judgments about the "quality of life" that a particular individual may enjoy,'" the Ninth Circuit employs the most dangerous form of utilitarian reasoning, unjustifiably devaluing the lives of terminally ill persons: "When patients are no longer able to pursue liberty or happiness and do not wish to pursue life, the state's interest in forcing them to remain alive is clearly less compelling." Wash. Pet. App. A-72. The Second Circuit is even more blunt (N.Y. Pet. App. 31a) (emphasis added):

> [W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes * * *. What concern prompts the state to interfere with a mentally competent patient's "right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life" * * *? The greatly reduced interest of the state in preserving life compels the answer to these questions: *"None."*

Both courts below have fallen into the same conceptual trap. They have looked to language in *Casey* and in this Court's other abortion cases which weigh against the rights of the woman, the variable state interest in protecting the life of a fetus, a state interest which this Court has found to vary with the fetus' increasing "potentiality" for life. *See Casey*, 505 U.S. at 869-73.[7] These precedents are totally inapposite, notwithstanding the fact that they do accord "potential life" at least some weight in the balance. *See Casey*, 505 U.S. at 871 (abortion may be restricted after viability).

In the case of assisted suicide, the value of life is not subject to a sliding scale. There is no disputing the status of terminally ill persons: they are persons at all times and for all constitutional purposes, and their lives have as much value and meaning as the life of any other person. *See Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995) (striking statute permitting physician assisted suicide by terminally ill persons because it denied them equal protection of the law). Thus, Washington and New York each have a paramount interest

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[7] Of course, this Court's entire abortion discussion proceeds from the assumption that the fetus is something less than a "person" recognized at law. *See Casey*, 505 U.S. at 982 (Scalia, J., concurring and dissenting). The CHA does not agree with the Court's conclusion, nor with its approach to statutes restricting or prohibiting abortion, but the Court's devaluation of the life of the fetus in abortion cases is still distinguishable from this case, involving other living persons.

in preserving life, and in ensuring equal protection of the law for all lives, including the lives of those who are terminally ill.

B. Preventing Suicide.

Washington and New York have decided that suicide is so dangerous to their citizens and to the social order that it ought to be a crime to aid or abet a person attempting to kill themselves. As shown above, these states are not alone, for suicide and assisted suicide have traditionally been prohibited. *See* Wash. Pet. App. A-39 to A-47; N.Y. Pet. App. 18a-19a; Section I.B, *supra*. Indeed, under most states' laws, those contemplating suicide are *per se* subject to involuntary commitment, and citizens have a privilege to interfere with anyone attempting to commit suicide. *Cruzan*, 497 U.S. at 298 (Scalia, J., concurring).

Neither Court of Appeals disputes the state's legitimate interest in preventing suicide. Instead, both courts apply the same flawed reasoning to this interest as they do to the state's interest in preserving life. In both cases, the courts below devalue the lives of terminally ill persons simply because they express a wish to die and are going to die anyway. However, the state's interest in preventing suicide does not diminish simply because a suicidal person "wants" to die.[8]

C. Protecting The Integrity Of The Medical Profession, Especially In A Managed Care Environment.

The state also has an important interest in protecting the integrity of the medical profession or, as Judge Noonan put it, denying to physicians "the role of killers of their

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[8] Of course, everyone who attempts suicide *claims* to "want" to die. However, as the Ninth Circuit admits, "[s]tudies show that many suicides are committed by people who are suffering from treatable mental disorders." Wash. Pet. App. A-73.

patients." *See Compassion in Dying v. Washington*, 49 F.3d 586, 593 (9th Cir. 1995), *vacated*, 79 F.3d 790 (9th Cir. 1996)(*en banc*). *See also* Edmund D. Pellegrino & David C. Thomasma, *For the Patient's Good* 205-206 (1988); Edmund D. Pellegrino & David C. Thomasma, *A Philosophical Basis of Medical Practice* (1981). The courts below dismiss this by simply assuming that states will adopt safeguards to protect patients, but the states' power to adopt safeguards does not lessen their interest in the first instance in seeking the most effective way to guard against the perversion of the role of a physician. Similarly, a health care environment dominated by managed care might create economic incentives which the state must properly offset through criminal legislation.

In response to the dramatic rise in health care expenditures, cost-conscious insurers have increasingly adopted principles of managed care. AMA, Council on Ethical & Judicial Affairs, "Ethical Issues in Managed Care," 273 JAMA 330 (1995). Managed care plans' techniques to control provider costs include fixed per-patient payments, restricted treatment options and financial incentives to promote efficient care. *Id.* The most tightly managed plans pay fixed sums for enrolling a patient. The amount of the provider's payment, therefore, is not dependent on whether services are rendered to the patient.

Managed care can serve many legitimate health policy purposes. Yet, managed care requirements can place physicians and other providers in situations rife with difficult ethical concerns. The needs of patients can conflict with the financial interests of providers. *Id.* at 331. In managed care settings, providers often accept some financial risk in the treatment of their patients. This risk may be substantial when treating terminally ill patients who often require expensive treatment. In addition, the economic incentives of managed care can be structured so as to inappropriately reward minimum treatment and the shortest possible hospital

stays. *Cf.*, Newborns' and Mothers' Health Protection Act of 1996, P.L. 104-204, 1996 HR 3666, 110 Stat. 2874, 2935 (Sept. 26, 1996) (requiring health plans offering childbirth benefits to provide minimum inpatient coverage for at least 49 hours following vaginal deliveries and 96 hours following cesarean sections). Health care providers feel these economic pressures. Porter Storey, M.D., medical director of the Texas Medical Center's hospice in Houston has stated "[t]he [financial] incentives in managed care make euthanasia the most cost-effective choice." R. Sorelle, "Fear of Pain," Hous. Chron., Oct. 21, 1996, at 1.

Providing constitutional protection for physician-assisted suicide would provide a new treatment "option" for patients. In order to satisfy the doctrine of informed consent, a physician could be legally obligated to disclose an "option" to physician-assisted suicide to terminally ill patients. *See* Barry R. Furrow, *et al.*, *Health Law* § 6-11(e), at 424 (1995). *See also* Patient Self-Determination Act, 42 U.S.C. §§ 1395cc(f)(1)(A)(i)-(ii), 1396a(w)(1)(A)(i)-(ii) (hospitals must inform patients of state law health care rights). Due to the financial incentives inherent in managed care, the physician could benefit financially from a patient's decision to commit suicide. This development may place a physician in a serious dilemma between the ethical constraint to "do no harm" and the ability to gain financially should the patient choose the now "legitimate" treatment option of physician-assisted suicide.[9] Of course, rather than trusting their providers, patients will then have to question the providers' motivations to discern the most appropriate course of treatment.

Recognizing a right to assisted suicide also raises a host

[9] The physician's hippocratic oath states "[I will] abstain from whatever is deleterious and mischievious. I will give no deadly medicine to anyone if asked, nor suggest any such counsel." AMA, *The Health Care Almanac* 120 (1995).

of difficult questions for health care providers which were dismissed by the lower courts as mere regulatory matters. Wash. Pet. App. A-102 to A-104; N.Y. Pet. App. 34a n.4. What if the physician morally objects to assisted suicide? Must hospitals which institutionally object to assisted suicide (*e.g.*, Catholic hospitals) be required to cooperate in the performance of such a procedure or allow physicians on staff who perform these acts? *Cf.* Directive 60 (App. B). How must payors cover assisted suicide costs? These are not merely hypothetical questions. *E.g.*, *Lee*, 891 F. Supp. 1429.

Recognizing a "right" to physician-assisted suicide will subvert the integrity of the medical profession. States not only have an important interest, but a compelling reason, to protect their citizens from abuses and to protect the integrity of the health care profession.

D. Preventing Abuse.

The state can and should prevent the involvement of third parties in so grave a matter as suicide. Even if suicide itself is not illegal, allowing others to take part in the process will increase the risk of abuse, and expose vulnerable patients to family and financial pressures from which they should be insulated.[10]

The state also has an interest, as it always has when enacting criminal legislation, in avoiding the adverse consequences anticipated from the actions it seeks to prohibit. *E.g.*, *People v. Kevorkian*, 210 Mich. App. 601, 534

[10] The Ninth Circuit acknowledges the risk of these pressures, but appears unconcerned:

> we are reluctant to say that, in a society in which the costs of protracted health care can be so exorbitant, it is improper for competent, terminally ill adults to take the economic welfare of their families and loved ones into consideration [in requesting assistance in committing suicide].

Wash. Pet. App. A-87.

N.W.2d 172, 175 (1995)(Dr. Kevorkian's "actions implicate the criminal law and his words and actions amount to an advertisement for criminal and unethical conduct"), *appeal denied*, 549 N.W.2d 566 (Mich. 1996), *cert. denied*, 65 U.S.L.W. 3287 (U.S. Oct. 15, 1996) (No. 96-135). Here, the state can legitimately point to the fear of abuse, undue influence and the improper killing of people in situations that are not truly voluntary. This has already happened in the Netherlands, where assisted suicide has been virtually legal for 15 years. Unfortunately, the attempt in the Netherlands to afford "compassion" to the dying has devolved into state-sanctioned non-voluntary euthanasia.

Between 1981 and 1991, the Dutch inexorably moved along a continuum from a heavily regulated regimen of physician-assisted suicide for the informed, competent adult to the non-voluntary euthanasia of infants. "Physician-Assisted Suicide and Euthanasia in the Netherlands," *Report to the Constitution Subcommittee of the House Committee on the Judiciary*, 104th Cong., 2d Sess. (1996) ("Constitution Subcommittee Report").

In 1991 the Dutch Attorney General issued the Remmelink Commission Report (*id.* at 12), finding that in 1990 there were:

> 2,300 cases of voluntary euthanasia;
>
> 400 cases of physician-assisted suicide; and
>
> *more than 1,000 cases of non-voluntary euthanasia.*

In order to justify these non-voluntary euthanasia cases, the Commission explained that

> [T]he ultimate justification for the intervention is in both cases the patient's unbearable suffering. So, medically speaking, there is little difference between these situations and euthanasia, because in both cases patients are involved who suffer terribly.

Constitution Subcommittee Report at 13, quoting Ministerie van justitie, Netherlands, *Outlines Report Commission Inquiry into Medical Practice with Regard to Euthanasia* 3 (1990). The Commission also found that 14 percent of the non-voluntary euthanasia cases were performed on patients who were fully competent and 11 percent of the patients were partially competent. *Id.*

The Commission also found that of the 8,100 cases of morphine overdose in 1990, in 36 percent of the cases the physician's single intent or partial intent was that the morphine kill the patient. *Id.* In over 50 percent of the cases, the physicians administered the morphine overdose without the patient's consent. *Id.* Twenty-seven percent of these non-consenting patients were fully competent. *Id.* The Commission also reported on 25,000 cases of withdrawal of life-sustaining treatment *without* the patient's consent. *Id.*

Our society has known from its earliest times that it was dangerous to allow any ambiguity in the rule against killing. The "rights" recognized by the Ninth Circuit and the Second Circuit are no innocuous grants of personal freedom. *Compassion in Dying* and *Quill* strike at the most fundamental ethical tenets of Western culture. Indeed, they are an invitation to murder. As Cardinal Bernardin states, "[t]here can be no such thing as a 'right to assisted suicide' because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent is self-administered. Creating a new 'right' to assisted suicide will endanger society and send a false signal that a less than 'perfect' life is not worth living." App. A at 2a.

CONCLUSION

The decisions of the United States Courts of Appeals for the Second and the Ninth Circuits should be reversed.

Respectfully submitted.

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NOVEMBER 1996.

APPENDIX A

STATEMENT OF JOSEPH CARDINAL BERNARDIN

The Supreme Court
of the United States
Washington, D.C.

Dear Honorable Justices:

I am at the end of my earthly life. There is much that I have contemplated these last few months of my illness, but as one who is dying I have especially come to appreciate the gift of life. I know from my own experience that patients often face difficult and deeply personal decisions about their care. However, I also know that even a person who decides to forgo treatment does not necessarily choose death. Rather, he chooses life without the burden of disproportionate medical intervention.

In this case, the Court faces one of the most important issues of our times. Physician-assisted suicide is decidedly a public matter. It is not simply a decision made between patient and physician. Because life affects every person, it is of primary public concern.

I have often remarked that I admire the writings of the late Father John Courtney Murray, who argued that an issue was related to public policy if it affected the public order of society. And public order, in turn, encompassed three goods: public peace, the essential protection of human rights, and commonly accepted standards of moral behavior in a community.

Our legal and ethical tradition has held consistently that suicide, assisted suicide, and euthanasia are wrong because they involve a direct attack on innocent human life. And it

is a matter of public policy because it involves a violation of a fundamental human good.

There can be no such thing as a "right to assisted suicide" because there can be no legal and moral order which tolerates the killing of innocent human life, even if the agent of death is self-administered. Creating a new "right" to assisted suicide will endanger society and send a false signal that a less than "perfect" life is not worth living.

Physician-assisted suicide also directly affects the physician-patient relationship and, through that, the wider role of physicians in our society. As has been noted by others, it introduces a deep ambiguity into the very definition of medical care, if care comes to involve killing. Beyond the physician, a move to assisted suicide and, perhaps beyond that, to euthanasia creates social ambiguity about the law. In civilized society the law exists to protect life. When it begins to legitimate the taking of life as a policy, one has a right to ask what lies ahead for our life together as a society.

In order to protect patients from abuse, and to protect society from a dangerous erosion in its commitment to preserving human life, I urge the Court not to create any right to assisted suicide.

With cordial good wishes, I am

Sincerely yours,

/s/ Joseph Cardinal Bernardin

Archbishop of Chicago

Chicago, Illinois
November 7, 1996

APPENDIX B

The National Conference of Catholic Bishops has directly dealt with euthanasia and assisted suicide. Directive 60 states:

> Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death.

National Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* 29 (1995).

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

VACCO *et al., Petitioners*, v. **QUILL** *et al., Respondents.*

On Writ Of Certiorari To The U.S. Court Of Appeals
For The Second Circuit

WASHINGTON *et al., Petitioners*, v. **GLUCKSBERG** *et al., Respondents.*

On Writ Of Certiorari To The U.S. Court Of Appeals
For The Ninth Circuit

BRIEF OF THE NATIONAL CATHOLIC OFFICE FOR PERSONS WITH DISABILITIES AND THE KNIGHTS OF COLUMBUS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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36 pp

QUESTION PRESENTED

Your Amici adopt the Questions Presented by the States of Washington and New York.

TABLE OF CONTENTS

TABLE OF AUTHORITIES iv

INTERESTS OF THE AMICI CURIAE 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. Our Nation Is Founded On The Principle That Fundamental Human Rights, Particularly The Right To Live, Are Unalienable; A Ruling Granting Constitutional Protection To An Interest In Obtaining Physician-Prescribed Drugs To Purposely Cause Death Would Abandon This Principle. 4

II. A Constitutional Rule Permitting Persons To Alienate Their Right To Live Because They Have, Or Are Regarded As Having, A Terminal Condition Lacks A Legitimate, Non-Invidious Basis. ... 10

A. *Considerations Under The Criminal Law: The Definition Of Homicide And The "Last Spark Of Life".* 12

B. *Considerations Under The Constitution: Fourteenth Amendment Exemptions And United States v. Rutherford.* 16

III. A Constitutionally-Mandated Policy Permitting The Selective Alienation Of The Right To Live Based On A Suicide Victim's Life Expectancy Threatens The Welfare And Safety Of Vulnerable Persons And Imperils Ordered Liberty. 17

A. *Unlike Any Other Constitutional Freedom, A "Right" To Alienate One's Right To Live Licenses The Intentional Destruction Of Persons' Lives.* .. 17

B. *A Constitutional Rule Establishing The Freedom To Renounce Society's Protection Of One's Right To Live Would Ratify The Most Extreme Form Of Social And Political Alienation.* 21

C. *A Constitutional Rule Limiting Assisted Suicide To Persons With Terminal Conditions Offers A False And Dangerous Compromise.* 22

CONCLUSION 25

TABLE OF AUTHORITIES

Constitutions

Ala. Const. Art. I, § 1 (1975) 5

Ark. Const. Art. 2, § 2 (1987) 5

Cal. Const. Art. 1, § 1 (1984) 5

Colo. Const. Art. II, § 3 (1973) 5

Fla. Const. Art. 1, § 2 (1990) 5

Haw. Const. Art. I, § 2 (1993) 5

Idaho Const. Art. I, § 1 (1993) 5

Ill. Const. Art. I, § 1 (1993) 5

Iowa Const. Art. 1, § 1 (1989) 5

Kan. Const. Bill of Rights § 1 (1980) 5

Ky. Const. Bill of Rights § 1 (1988) 5

La. Const. Art. 1, § 1 (1996) 5

Mass. Const. Pt. 1, Art. I, (1978) 5

Me. Const. Art. I, § 1 (1985) 5

Miss. Const. Art. 3, § 19 (1974) 5

Mont. Const. Art. II, § 3 (1995) 5

N.C. Const. Art. I, § 1 (1995) 5

N.D. Const. Art. I, § 1 (1981) 5

N.H. Const. Pt. 1, Art. 2 (1988) 5

N.J. Const. Art. 1, para. 1 (1971) 5

N.M. Const. Art. II, § 4 (1992) 5

Neb. Const. Art. I, § 1 (1995) 5

Nev. Const. Art. 1, § 1 (1995) 5

Ohio Const. Art. I, § 1 (1994) 5

Pa. Const. Art. I, § 1 (1994) 5

Utah Const. Art. I, § 1 (1991) 5

Va. Const. Art. I, § 1 (1995) 5

Vt. Const. Chap. I Art. 1 (1996) 5

W. Va. Const. Art. III, § 1 (1983) 5

Statutes

N.Y. Penal Law §§ 120.30 & 125.15 (McKinney 1987) 2

Wash. Rev. Code Ann. § 9A.36.060 (West 1975) 2

Federal Cases

Board of Regents of State Colleges v. Roth, 408 U.S. 564 (1972) 18

City of Cleburne v. Cleburne Living Center, Inc., 473 U.S. 432 (1985) 10

Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) 2, 12, 13, 17, 18, 20, 22, 23

Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) 19

Gulf, Colorado & Santa Fe Railway v. Ellis, 165 U.S. 150 (1897) 6

Haig v. Agee, 453 U.S. 280 (1981) 25

Kennedy v. Mendoza-Martinez, 372 U.S. 144 (1963) 25

McGowan v. Maryland, 366 U.S. 420 (1961) 6

Meachum v. Fano, 427 U.S. 215 (1976) 17

Monangahela Navigation Co. v. United States, 148 U.S. 312 (1893) 6

Montana v. Egelhoff, 64 U.S.L.W. 4500 (U.S. June 13, 1996) (No. 95-566) 14

Morrissey v. Brewer, 408 U.S. 471 (1972) 18

Paris Adult Theatre I v. Slaton, 413 U.S. 49 (1972) 7

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992) 10, 20

Quill v. Vacco, 80 F.3d 716 (1996) 2, 12, 17, 18, 23

United States v. Rutherford, 442 U.S. 544 (1979) 16

Washington v. Harper, 494 U.S. 210 (1990) 19

Whalen v. Roe, 429 U.S. 589 (1977) 19

State Cases

Fosmire v. Nicoleau, 551 N.Y.S. 2d 876, 551 N.E.2d 77 (N.Y. 1990) 11

Gilbert v. State, 487 So. 2d 1185 (Fla. App. 1986) 13

In re Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987) 11

Jones v. State, 640 So. 2d 1084 (Fla. 1994) 15

Martin v. Commonwealth, 184 Va. 1009, 37 S.E.2d 43 (1946) 7

People v. Moan, 4 P. 545 (Cal. 1884) 13

People v. Stamp, 82 Cal. Rptr. 598 (Cal. App.), *cert. denied*, 400 U.S. 819 (1970) 14

State v. Francis, 149 S.E. 348 (S.C. 1929) 14

State v. Fuller, 203 Neb. 233, 278 N.W.2d 756 (1979) .. 13, 15

State v. Mally, 366 P.2d 868 (Mont. 1961) 14

State v. Moore, 25 Iowa 128 (1868) 7

State v. O'Brien, 46 N.W. 752 (Iowa 1890) 15

Treatises and Journal Articles

Avila, *Is the Constitution a Suicide Pact?*, 35 Duquesne Law Review 201 (1996) 14

Feinberg, *Voluntary Euthanasia and the Inalienable Right to Life*, 7 Philosophy & Public Affairs 93 (1978) 7

Fiedler, *The Tyranny of the Normal*, Hastings Center Report, Apr. 1984, at 40 9

Hendin, *Seduced by Death* (1997) 13

Himmelfarb, Note, *The Constitutional Relevance of the Second Sentence of the Declaration of Independence*, 100 Yale L. J. 169 (1990) 6

McConnell, *The Nature and Basis of Inalienable Rights*, 3 Law and Philosophy 25 (1984) 4

Meisel, *The Right to Die* (2d ed. 1995) 10, 11

Meyer, *The History and Meaning of the Fourteenth Amendment* (1977) 6

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Sieghart, *The Lawful Rights of Mankind: An Introduction to the International Legal Code of Human Rights* (1985) 6

Stell, *Dueling and the Right to Life*, 90 Ethics 7 (1979) 8

White, *The Philosophy of the American Revolution* (1978) . 8

Miscellaneous

Amicus Curiae Brief of the Americans for Death With Dignity and Euthanasia Research & Guidance Organization, *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (No. 94-35534) 13

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Declaration of Independence (U.S. 1776) 4

Opposition to Petition for Writ of Certiorari, *Washington v. Glucksberg* (No. 96-110) 14

Samuel Adams, *The Rights of the Colonists, in* The Founders' Constitution 394 (Philip B. Kurland & Ralph Lerner eds. 1987) 5

Universal Declaration of Human Rights, *reprinted in* Paul Sieghart, *The Lawful Rights of Mankind: An Introduction to the International Legal Code of Human Rights* 172 (1985) . 6

INTERESTS OF THE AMICI CURIAE

The National Catholic Office for Persons with Disabilities (NCPD is a non-profit organization established in 1982 to promote the inclusion of ten million Catholics with disabilities and their families into the mainstream of our society and the Catholic Church. It fulfills its mission through offering its expertise and resources to a national network of disability offices as well as to the U.S. Catholic Conference and other national Church-related organizations. A critical aspect of this nation office's mission is to highlight the value of each life and to encourage the creation of environments which allow each individual to fulfill their potential. If a "right" to assisted suicide for the terminally ill is lodged in the Constitution, then the goals and programs NCPD is pursuing in the interest of persons with disabilities will be for nought. NCPD opposes the legal and social devaluation of persons with disabilities, many of whom have or are regarded as having terminal conditions. Such devaluation will surely result from a constitutional rule transforming their fundamental right to life from an unalienable right to a merely alienable interest based solely on life expectancy.

The Knights of Columbus is an international Catholic fraternal organization of 1.5 million members dedicated to advancing the ideals of charity, unity, fraternity, and patriotism through its activities around the world. The Knights of Columbus engages in a broad range of social action programs to protect the family, and it devotes a considerable portion of its resources and volunteer efforts to aiding persons with illnesses and disabilities, as well as the less fortunate. This brief was written with the support of funds provided by the Knights.

The parties have consented to the filing of this brief. Pursuant to the Rules of this Court, letters of consent from the parties have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

This brief examines the consequences of mandating the selective alienation of the right to live by constitutionalizing an exemption to the homicide code based on the terminal condition of the victim, enabling physicians to assist in suicide by prescribing a lethal drug overdose. Your Amici argue that the decisions in *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996), and *Quill v. Vacco*, 80 F.3d 716 (1996), involving Fourteenth Amendment challenges to Wash. Rev. Code Ann. § 9A.36.060 (West 1975) and N.Y. Penal Law §§ 120.30 & 125.15 (McKinney 1987), should be reversed.

The rulings below threaten the integrity of our Nation's social covenant, founded as it was on the belief that certain human rights are so fundamental in nature that they cannot be alienated. The Declaration of Independence announced to the world that the American colonists could no longer endure British encroachments on their fundamental and unalienable interests, including especially their right to life. So the doctrine of unalienable rights provided the basis for rebellion and launched a new experiment in American self-governance. Bound up as it is within our legal history and tradition, the governmental duty to respect the unalienable rights of the people serves to this day as a safeguard against tyranny.

The constitutional rule proposed by the courts below would radically transform the right to live from an unalienable right to a merely alienable interest for the most vulnerable persons in society — those having or regarded as having terminal conditions. The rule would permit members of this class to renounce the protections of the homicide code by consenting to another's criminal act of providing suicide assistance, and would force the states to treat the lives of all members of this class as less worthy of protection against homicide. The rule would discount the right to live for all members of this class, regardless of whether they seek to die or desire to live.

At the same time, the rule would endorse the purposeful causing of death, a "right" wholly unique in constitutional law because it encompasses an abuse of liberty. Every other protected freedom is closely related to the constitutional objectives of preserving existence and providing opportunities for social participation. By extending this "right" only to persons with terminal conditions, the courts below would further subject members of this class to social alienation and devaluation.

The lower courts misread the common and statutory law by deriving therefrom a line based on the victim's terminal condition to distinguish the supposed "right" to purposely cause death from the criminal wrong of assisted suicide. Their decisions conflict with the criminal law, which rejects criminal defenses based on the victim's life expectancy and consent. The courts impinged upon the states' exclusive authority to define crimes by mandating such defenses as a constitutional rule. Moreover, the rulings below conflict with this Court's decision in the case of *United States v. Rutherford*, 442 U.S. 544 (1979). *Rutherford* rejected the federal courts' authority to carve a terminal condition exception into otherwise uniform laws designed to protect all persons against dangerous drugs regardless of their life expectancy.

A rule that deems the suicides of persons with terminal conditions to be constitutionally permissible, while leaving the states free to continue their protection of all other persons, inserts into the Constitution an invidious double standard. This Court should reject such a rule and uphold the states' authority to protect the lives of all of its citizens, regardless of condition. The Constitution should not be construed as if it were a suicide pact.

ARGUMENT

I. Our Nation Is Founded On The Principle That Fundamental Human Rights, Particularly The Right To Live, Are Unalienable; A Ruling Granting Constitutional Protection To An Interest In Obtaining Physician-Prescribed Drugs To Purposely Cause Death Would Abandon This Principle.

The Ninth and Second Circuits recognized in *Compassion in Dying* and *Quill* a constitutional right to renounce the protections of the homicide code which deter persons from assisting in the suicides of others with terminal conditions. Properly understood, the alienation of the right to live involves the rejection of otherwise applicable protections against direct threats to one's life. As one commentator explains, "What is given up in the case in which the right to life is waived . . . is not life itself; rather it is the *protection* of life that that right bestows on its possessor." Terrence McConnell, *The Nature and Basis of Inalienable Rights*, 3 Law and Philosophy 25, 37 (1984). Consequently, the constitutional claim before this Court asserts in essence that at least some individuals should be empowered to forgo their right to be protected under the homicide code, thereby alienating their right to live.

If adopted by this Court, then a constitutional rule authorizing some individuals to alienate their right to live based on their life expectancy would undermine principles embraced in the Declaration of Independence. The Declaration put the case for the American rebellion against British rule. The American colonists charged England with "injuries" to and "usurpations" of "certain unalienable rights", including "among these . . . life". Because the King and Parliament assumed a form of government "destructive of these ends", the people had the right to "alter" or "abolish" the old and "institute [a] new government". *The Declaration of Independence* para. 2 (U.S. 1776). In sum, the unalienable rights doctrine provided the essential basis for the American Revolution.

The Declaration's principles have acquired a life of their own, extending their influence far beyond the document's four corners. There is universal agreement that it is,

> the greatest absurdity to suppose it in the power of one or any other number of men at the entering of society, to renounce their essential natural rights, or the means of preserving those rights when the great end of civil government . . . is for the support, protection and defence of those very rights [including] life . . . .

Samuel Adams, *The Rights of the Colonists, in* The Founders' Constitution 394, 395 (Philip B. Kurland & Ralph Lerner eds. 1987).

Twenty-nine states have either expressly incorporated the unalienable rights doctrine into their constitutions or adopted constitutional provisions comporting with the doctrine.[1] Furthermore,

> *the Declaration of Independence is . . . funda-*

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[1]The constitutions of twenty three states refer expressly to the "unalienable" or "inalienable" right to life. *See* Ala. Const. Art. I, § 1 (1975); Ark. Const. Art. 2, § 2 (1987); Cal. Const. Art. 1, § 1 (1984); Colo. Const. Art. II, § 3 (1973); Fla. Const. Art. 1, § 2 (1990); Haw. Const. Art. I, § 2 (1993); Idaho Const. Art. I, § 1 (1993); Ill. Const. Art. I, § 1 (1993); Iowa Const. Art. 1, § 1 (1989); Kan. Const. Bill of Rights § 1 (1980); Ky. Const. Bill of Rights § 1 (1988); Me. Const. Art. I, § 1 (1985); Mass. Const. Pt. 1, Art. I, (1978); Mont. Const. Art. II, § 3 (1995); Neb. Const. Art. I, § 1 (1995); Nev. Const. Art. 1, § 1 (1995); N.J. Const. Art. 1, para. 1 (1971); N.M. Const. Art. II, § 4 (1992); N.C. Const. Art. I, § 1 (1995); N.D. Const. Art. I, § 1 (1981); Ohio Const. Art. I, § 1 (1994); Utah Const. Art. I, § 1 (1991); Vt. Const. Chap. I Art. 1 (1996). Three other state constitutions refer either to a right to life that is "indefeasible" (Pa. Const. Art. I, § 1 (1994), or one that cannot be "divest[ed]". Va. Const. Art. I, § 1 (1995) & W. Va. Const. Art. III, § 1 (1983). New Hampshire's constitution refers to the right to life as "natural", "essential" and "inherent". N.H. Const. Pt. 1, Art. 2 (1988). Two other state constitutions contain provisions that comport with the unalienable rights doctrine. La. Const. Art. 1, § 1 (1996) (prohibiting euthanasia) & Miss. Const. Art. 3, § 19 (1974) (prohibiting duelling).

> *mental to a proper understanding of the [federal] Constitution;* and . . . abundant support for this proposition can be found in the leading writings and debates of the Founding era. Indeed, it would hardly be an exaggeration to say that the most fundamental pronouncements made in connection with the framing and ratification of the Constitution are restatements of the principles articulated in the [Declaration] . . . .

Dan Himmelfarb, Note, *The Constitutional Relevance of the Second Sentence of the Declaration of Independence*, 100 Yale L. J. 169, 170-71 (1990) (emphasis added); *see also Monangahela Navigation Co. v. United States*, 148 U.S. 312, 324 (1893) (noting that the Bill of Rights was adopted to protect "those rights of persons and property which by the Declaration of Independence were affirmed to be unalienable rights"); *Gulf, Colorado & Santa Fe Railway v. Ellis*, 165 U.S. 150, 159-60 (1897); *McGowan v. Maryland*, 366 U.S. 420, 563 (1961) (Douglas, J., dissenting) ("[T]he body of the Constitution as well as the Bill of Rights enshrined those principles [of the Declaration].").

The Fourteenth Amendment was drafted with the Declaration very much in mind. *See* Hermine H. Meyer, *The History and Meaning of the Fourteenth Amendment* 75 (1977) (referring to remarks during congressional debates on the Amendment by a sponsor, Representative Thaddeus Stevens, who observed that "I can hardly believe that any person can be found who will not admit that every one of these provisions is just. They are all asserted, in some form or other, in our DECLARATION or organic law.") (capitalization in original).

Finally, the unalienable rights doctrine serves as an international measure of humane and just governments. *See* Preamble to the Universal Declaration of Human Rights, *reprinted in* Paul Sieghart, *The Lawful Rights of Mankind: An Introduction to the International Legal Code of Human Rights* 172 (1985) (asserting that "recognition of the inherent dignity and

of the equal and inalienable rights of the all members of the human family is the foundation of freedom, justice and peace in the world"); *id.* at 42 (observing that while international human rights law recognizes that some rights can be acquired or renounced through personal transactions, "none of this applies to 'human' rights. . . . [T]he code [of international human rights laws] simply treats us as coming into the world with them. . . . nor can we sell them, mortgage them, or forfeit them").

Assisted suicide and voluntary active euthanasia "can both be viewed as efforts to alienate the inalienable, to give away what cannot properly cannot be given away." Joel Feinberg, *Voluntary Euthanasia and the Inalienable Right to Life*, 7 Philosophy & Public Affairs 93, 93 (1978). In accord with this principle, the states have prohibited the aiding and abetting of suicide, along with other forms of consensual homicide and self-harm. *See, e.g., Paris Adult Theatre I v. Slaton*, 413 U.S. 49, 68 n.15 (1972) (referring to laws against such consensual activities as "bare fist" prize fights and duelling); *Martin v. Commonwealth*, 184 Va. 1009, 37 S.E.2d 43, 47 (1946) (consent is no excuse for homicide because the right to life is unalienable); *State v. Moore*, 25 Iowa 128, 135-36 (1868) (recognizing that the "right to life and to personal safety is not only sacred in the estimation of the common law, but it is inalienable").

Accordingly, this Court should not abandon a core doctrine upon which this Nation was founded, but instead should affirm laws that, by uniformly forbidding suicide assistance, preserve the unalienability of the right to live and thereby respect the equal dignity of all persons. Such laws reflect our founding principles, and they are just as vital to our society today as they were 200 years ago.

As one commentator explained,

> [the Declaration] linked the unalienable rights of individuals with the people's right to rebel. In the background there is the basic idea that a

> social contract of some sort had been made in which the people transferred certain rights to government in return for something. . . . What rights the people transferred is less important than the rights they did *not* transfer because they were not transferable, that is to say, unalienable. Unalienable rights were thought to be held under *any* form of government so that when a government merely showed signs of wishing to invade these rights, it could be regarded as intending to reduce the people under absolute despotism.

Morton White, *The Philosophy of the American Revolution* 239-40 (1978).

In view of the nexus between unalienable rights and the limits on despotic governance, a constitutional policy endorsing the selective alienation of the right to live raises profound questions. As one commentator has observed, "[W]e must recall that [John Locke] puts the inalienability of the right to life to good purposes when he uses it to explain why a government can never legitimately acquire an absolute rule to dispose of the lives of its citizens." Lance K. Stell, *Dueling and the Right to Life*, 90 Ethics 7, 16 (1979). Thus, the right to live is a fundamental human interest "that no man *should* transfer to any person or any government." White, *American Revolution* at 220.

What damage will be inflicted on the inviolability of life by a constitutional rule rejecting its unalienability? Will governments be free to acquire absolute dominion over persons whose fundamental rights are deemed personally transferable and thus disposable? Will society become even more coursened in its disregard for the sanctity of human life? These questions cannot be ignored because constitutional rules cannot be imposed in a vacuum.

Moreover, a rule supposedly grounded in notions of autonomy and individual freedom will unjustifiably alter the

legal status of those who have no desire to kill themselves, but who nevertheless will be swept into the category of persons deemed to have an alienable right to live. The right to live and all rights flowing therefrom will be rendered alienable not because an individual so chooses, but on account of the individual's condition. If some persons with terminal conditions are permitted to alienate their right to live because they are terminally ill, then all persons with terminal conditions will necessarily be free to make the same choice. As a consequence, by virtue of constitutional mandate and irrespective of individual desires, the right to live for all members of this class will be reduced to an inferior, alienable status. Because every member of the affected class will no longer possess an unalienable right to live, each will be left with a weaker claim, or no claim at all, against tyrannical notions of "normalcy" and "quality of life" policy-making.[2]

Finally, a constitutional rule that permits some — but not all — persons to alienate their right to live cannot be squared with the Declaration's finding and the Fourteenth Amendment's proviso that *all* persons are created equal and as a result are equally endowed with unalienable rights. Once it is posited that some persons have only an alienable right to live, then an inequality of human dignity profoundly hostile to our Nation's founding principles not only will threaten the fundamental interests of the vulnerable, but also

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[2]One commentator has remarked on

> just how dangerous enforced physiological normality is when the definition of its parameters falls into the hands of politicians and bureaucrats. . . . [T]he war against "abnormality" implies a dangerous kind of politics, which begins with a fear of difference and eventuates in a tyranny of the normal. That tyranny, moreover, is sustained by creating in those outside the norm shame and self-hatred — particularly if they happen to suffer from that vast majority of "deformities" which we still cannot prevent or cure.

Leslie A. Fiedler, *The Tyranny of the Normal*, Hastings Center Report, Apr. 1984, at 40, 41, 42.

will imperil the integrity of our constitutional order.

II. A Constitutional Rule Permitting Persons To Alienate Their Right To Live Because They Have, Or Are Regarded As Having, A Terminal Condition Lacks A Legitimate, Non-Invidious Basis.

The Ninth and Second Circuits ruled that at least in some cases suicide assistance is constitutionally protected, and that a line must be drawn between the criminal wrong and the constitutional right based on the victim's life expectancy. The "courts may not", however, "draw lines which appear arbitrary without . . . offering a justification." *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 870 (1992). The line chosen by the lower courts not only *is* arbitrary, but also is based on the invidious assumption that the lives of persons with terminal conditions are less worthy or deserving of protection.[3]

The Ninth and Second Circuits claimed that the common law and state statutes governing treatment refusals provided the basis for recognizing in the assisted suicide context a diminishing state interest in "preserving" the lives of persons with terminal conditions. The courts misread the law, however, and confused an interest in "preserving" life with the states' separate interest in "protecting" life.

The "terminal condition" line cannot be adduced from an accurate reading of the common law of informed consent, which extends the right to refuse treatment to all persons regardless of life expectancy. 1 Alan Meisel, *The Right to Die* 490-91 (2d ed. 1995) (referring to case law extending the right to refuse treatment to persons who are not terminally

[3] *See City of Cleburne v. Cleburne Living Center, Inc.*, 473 U.S. 432, 440 (1985) (observing that certain classifications "are so seldom relevant to the achievement of any legitimate state interest that laws grounded in such considerations are deemed to reflect prejudice and apathy — a view that those in the burdened class are not as worthy or deserving as others").

ill). Advance directive statutes often limit their scope to cases involving incompetent persons who are terminally ill, but they must be read together with the broader common law rule. Rather than limiting treatment refusals, these statutes establish a legal "safe harbor" for advance directive decision making. *See* 2 Meisel, *The Right to Die* at 85 (noting that most advance directive statutes expressly decline to supersede the common law or to set out the sole means by which the right to refuse treatment may be exercised; also noting that a majority of courts has therefore concluded that such legislation does not preempt or otherwise narrow the common law).

Moreover, whether a person has a terminal condition is relevant to the treatment refusal context only for reasons quite irrelevant to the assisted suicide context. When weighing the benefits and burdens of accepting medical treatment, a patient must necessarily consider the treatment's capacity to extend life. If a patient is terminally ill, so that the treatment will not extend his or her life indefinitely, then the state's interest in preserving life will not be implicated. *See In re Grant*, 109 Wash. 2d 545, 556, 747 P.2d 445, 451 (1987) (observing that state interest in "preserving life" by requiring "lifesaving" treatment "weakens considerably . . . if treatment will merely postpone death for a person with a terminal and incurable condition"). The state's interest in preserving life is measured according to the effectiveness of treatment in question, and does not depend on any value assessment of the lives at stake. *See also Fosmire v. Nicoleau*, 551 N.Y.S. 2d 876, 881, 551 N.E.2d 77, 82-83 (1990) (holding that patients' terminal condition is relevant only "to determine whether [this is] the circumstance[] in which the patients intended to decline the medical care" and not "because the State considered their lives worthless").

In the assisted suicide context, however, the issue is not whether the state has an interest in *preserving* life by providing treatment, but whether the state may seek to *protect* all lives against direct killing. Persons with terminal conditions are still alive, whether or not their lives can be indefinitely extended by life supports. Thus, even when it is impossible

to effectuate the state's interest in preserving their lives because life-sustaining measures are unavailing, the separate issue remains as to whether the state's interest in protecting life against killing should apply.

Consequently, the lower courts engaged in pretextual reasoning by referring to the common law of consent and the statutory law governing advance directives as bases for drawing a line at terminal condition. *See Compassion in Dying*, 79 F.3d at 817-20 and *Quill*, 80 F.3d at 727-28; *but see* 79 F.3d at 819 (quoting preamble to Washington's advance directive statute expressing the legislature's finding that without qualification "adult persons" have the right to control medical decisions, and importantly, that this right is not limited to but "*includ[es]*" those decisions involving "instances of terminal condition", thereby extending the right to refuse treatment both to persons who are and who are not terminally ill) (emphasis added) & *Fosmire*, 551 N.Y.S.2d at 881, 551 N.E.2d at 82 (finding that common law right to refuse treatment in New York extends to all competent adults regardless of condition).

As the next two sections will demonstrate, neither the criminal law nor the constitutional rulings of this Court provide an alternate basis for mandating an exemption from the homicide code based on the victim's life expectancy. To the contrary, our legal history and tradition, as well as this Court, have rejected the victim's condition as constitutionally irrelevant.

A. *Considerations Under The Criminal Law: The Definition Of Homicide And The "Last Spark Of Life".*

Criminal jurisprudence provides an instructive approach to resolving whether a non-invidious foundation exists for using a suicide victim's terminal condition as a constitutional dividing line. Many of the arguments favoring a limited right to assisted suicide for persons with terminal conditions resemble the defenses that might be raised in a trial for homicide. Thus, the definitional elements of causation, intent,

excuse, and justification provide a useful framework for addressing — and ultimately rejecting — any claim that a suicide victim's life expectancy is at all constitutionally relevant.

For example, the Ninth Circuit raised an argument sounding in causation by contending that a decision to hasten death should not be classified as suicide when the victim's "death is already in process". *Compassion in Dying*, 79 F.3d at 824. *But see People v. Moan*, 4 P. 545 (Cal. 1884) ("If a patient is lying in the last stages of consumption, with a tenure upon life that cannot possibly continue for a day, it is homicide to administer a poison to him by which his life is ended almost immediately.")

In addition, an amicus brief filed with the Ninth Circuit asserted that in cases involving suicidal persons with terminal conditions, the participants necessarily lacked the requisite criminal intent. Instead, the suicide assistant "seeks to end the [victim's] dying process", and the victim "does not have the primary goal of ending his life", because "[g]iven the terminal nature of his condition, the [victim] wants to end his suffering by shortening the dying process." Amicus Curiae Brief of the Americans for Death With Dignity and Euthanasia Research & Guidance Organization at 4 n.6, *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (No. 94-35534). *But see Gilbert v. State*, 487 So. 2d 1185, 1191 (Fla. App. 1986) (rejecting defense to homicide based on claim that defendant sought only to end the victim's suffering because it would "sanction open season" for the killing of vulnerable persons).

Moreover, assisted suicide is defensible in The Netherlands on the excuse-related ground that a physician charged with a crime should not be convicted if he or she participated in a suicide under emotional duress, and was compelled to end another's misery when confronted with the victim's condition. Herbert Hendin, *Seduced by Death* 94, 103, 109 (1997). *But see State v. Fuller*, 203 Neb. 233, 243, 278 N.W.2d 756, 762 (1979) ("Duress or compulsion is no excuse to the charge of homicide.").

Finally, the respondents in *Glucksberg* raise a justification-related defense by asserting that any conflict between the state's interest in protecting life and an individual's interest in death must tilt in favor of death when the life at stake is of a "limited *quantity*". Opposition to Petition for Writ of Certiorari at 12, *Washington v. Glucksberg* (No. 96-110). *But see State v. O'Brien*, 46 N.W. 752, 753 (Iowa) ("The fact that [the homicide victim] was afflicted with a disease which might have proved fatal would not justify the wrongful acts of defendant . . . .").

The Ninth and Second Circuits would impose these theories on the states as constitutional mandates, contrary to this Court's long line of precedents leaving to the states the authority to define crimes, particularly in reference to the "doctrines of *actus reus, mens rea,* insanity, mistake, justification and duress". *Montana v. Egelhoff*, 64 U.S.L.W. 4500, 4505 (U.S. June 13, 1996) (No. 95-566). Moreover, such mandates would conflict with our legal history and tradition, which unanimously reject any defenses to homicide based on the victim's health status.

One court described the rule of law as follows:

> But though a human body must be alive in order that it may be the subject of homicide, yet the quantity of vitality which it retains at the moment the fatal blow is given, and the length of time life would otherwise have continued, are immaterial considerations. If any life at all is left in the human body, even the least spark, the extinguishment of it is as much homicide as the killing of the most vital being.

State v. Francis, 149 S.E. 348, 364 (S.C. 1929). *Accord State v. Mally*, 366 P.2d 868, 873-74 (Mont. 1961); *People v. Stamp*, 82 Cal. Rptr. 598, 603 (Cal. App.), *cert. denied*, 400 U.S. 819 (1970); *see* Daniel Avila, *Is the Constitution a Suicide Pact?*, 35 Duquesne Law Review 201, 227-230 (1996) (discussing these and other cases).

In light of this rule and its broad acceptance in our law, any attempted justification for abandoning to their suicidal impulses only persons with terminal conditions, and exposing only them to the undeterred efforts of others to assist in their deaths, bolsters the inference that an invidious disregard for the lives of the vulnerable is at play. If "[a]n accused cannot speculate as to how long his victim may live with an incurable malady when he inflicts a shot or a wound that hastens the death or the action of the fatal disease" (*State v. O'Brien*, 46 N.W. 752, 753 (Iowa 1890)), then neither should the Constitution.

If this Court were to adopt the contrary position and hold as a matter of constitutional law that the victim's proximity to death is relevant to the culpability of an individual charged with assisting suicide, then the definitional ramifications would be far-reaching. Assisted suicide cannot be distinguished from other forms of homicide. If the victim's condition is deemed relevant in the assisted suicide context, then it must also be relevant in any case of homicide. As a result, virtually any defendant accused of a homicidal act would have the constitutional right to raise the victim's debilitated condition as a defense.

By definition then, crimes against life would be limited only to those life-threatening acts which imperil the healthy and long-living. Those charged with mortally attacking an individual deemed to be in an accelerated "process of dying" could avoid conviction. Because "process of dying" is an inherently expansive concept — all persons are going to die sometime and many are going to die sooner than expected for a variety of reasons — an assortment of defense claims based on the victim's condition would emerge in a host of cases.[4]

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[4]Such a rule would also open the door to constitutional defenses based on the victim's consent, thereby overriding state policies rejecting such defenses in cases involving homicide and other crimes. *See, e.g., State v. Fuller*, 203 Neb. at 241, 278 N.W.2d at 761 (holding that "murder is no less murder because the homicide is committed at the desire of the victim"); *Jones v. State*,

B. *Considerations Under The Constitution: Fourteenth Amendment Exemptions And United States v. Rutherford.*

This Court's unanimous decision in *United States v. Rutherford*, 442 U.S. 544 (1979), rejected a similar exemption based on a person's terminal condition. The Court ruled that a uniform federal ban against the interstate transfer of unsafe or unproven drugs reasonably applied to an experimental and potentially harmful substance (laetrile) sought by persons with terminal cancer as a last ditch means of extending their lives. *Id.* at 559. The Court found that "[f]or the terminally ill, as anyone else, a drug is unsafe if its potential for inflicting death or physical injury is not offset by the possibility of therapeutic benefit." *Id.* at 556. Moreover, "it is often impossible to identify a patient as terminally ill except in retrospect." *Id.* at 556. Finally, the Court was unwilling to endorse the proposition "that . . . safety and efficacy standards . . . have no relevance for terminal patients" because this would "deny the [government's] authority over all drugs, however toxic or ineffectual, for such individuals." *Id.* at 557-58. Thus, the Court refused to read an implied exception into an otherwise generally applicable statute since "federal courts do not sit as councils of revision, empowered to rewrite legislation in accord with their own conceptions of prudent public policy." *Id.* at 555.

Rutherford should pose a significant obstacle to any constitutional claim for assisted suicide based on a victim's proximity to death. If Congress may restrict the use of dangerous drugs by persons with terminal conditions seeking to prolong their lives, then surely the states may deter physicians from supplying lethal dosages to members of the same class who want to end their lives. The parallels between the two cases simply cannot be ignored.

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640 So. 2d 1084 (Fla. 1994) (rejecting claim of a right to such a defense under the state constitution in a case involving charges brought under statutory rape law, even though the victim "did not want the 'protections' advanced by the state").

Thus, in light of *Rutherford*, laws discouraging drug-induced deaths among the terminally ill, as for anyone else, reasonably furthers the states' general goal of protecting life. The constitutional balance between state interests and competing private interests should not be shifted according to the victim's life expectancy. In sum, the terminally ill are similarly situated with everyone else in relation to the states' interest in protecting life. For the Court to hold otherwise, it would have to abandon *Rutherford* and entirely reverse its course with respect to constitutional exemptions generally.

III. A Constitutionally-Mandated Policy Permitting The Selective Alienation Of The Right To Live Based On A Suicide Victim's Life Expectancy Threatens The Welfare And Safety Of Vulnerable Persons And Imperils Ordered Liberty.

To deflect concerns about assisted suicide raised by persons with disabilities and members of other vulnerable populations, the Ninth and Second Circuits responded with assurances that suicide is a constitutional benefit. *Compassion in Dying*, 79 F.3d at 825-26; *Quill*, 80 F.3d at 730. Based on the considerations addressed in the remainder of this brief, your Amici disagree strongly.

A. *Unlike Any Other Constitutional Freedom, A "Right" To Alienate One's Right To Live Licenses The Intentional Destruction Of Persons' Lives.*

In no other case has the Supreme Court been asked to license an individual to assist in the intentional destruction of life at the request of the victim. All other claims of personal freedom granted constitutional protection have related in some meaningful way to the individual's enjoyment of life and continued participation in society. Thus, the Supreme Court has "reject[ed] at the outset the notion that *any* grievous loss visited upon a person by the State is sufficient to invoke" a constitutional remedy. *Meachum v. Fano*, 427 U.S.

215, 224 (1976). Whether an asserted interest to act free from government interference rises to the level of a constitutional right will depend on its "nature" — that is, its relation to the "'whole domain of social and economic fact'" (*Morrissey v. Brewer*, 408 U.S. 471, 481 (1972) (citation omitted)), as well as on its connection to an individual's ability to "'engage in any of the common occupations of life'". *Board of Regents of State Colleges v. Roth*, 408 U.S. 564, 572 (1972) (citation omitted).

Conversely, a "right" or "liberty" to obtain suicide assistance would lack any relation to the capacity to exist, move freely, and form personal attachments in society; it would be entirely antithetical to such exercises of liberty. *See Morrissey*, 408 U.S. at 482 (holding parole to be cognizable Fourteenth Amendment liberty because it "enables [offenders] to do a wide range of things open to persons who have never been convicted of any crime" such as "to return to society", "be gainfully employed", be "free to be with family and friends and to form the other enduring attachments to normal life"). Assisted suicide accomplishes the purposeful destruction of life and, as a result, forever cuts the victim off from all ties to family, friends, and society. It thus fails to achieve any "benefit" of existence or social inclusion ascertainable under the Constitution.

The Ninth and Second Circuits attempted to graft assisted suicide to the outer branches of the right to accept or refuse medical treatment. *Compassion in Dying*, 79 F.3d at 822-23 (discussing acceptance of morphine drips and refusal of tube-feeding); *Quill*, 80 F.3d at 729 (same). They argued that if the Constitution recognizes a right to make medical decisions, then it should recognize the right to assisted suicide. The courts thus contended that the personal and state interests at stake in treatment refusal and assisted suicide cases are indistinguishable, particularly with respect to their relationship to death.

On the contrary, the right to accept or refuse treatment differs significantly from an interest in suicide assistance

precisely because treatment decisions can enable persons to "engage in the common occupations of life". Moreover, the constitutional strength of an interest in making treatment decisions diminishes as the risk of death increases, while the proposed interest in assisted suicide would increase in strength *because* its objective is death.

This Court has acknowledged the existence of a "right to decide independently, with the advice of [a] physician, to acquire and to use *needed* medication [i.e., essential to health]." *Whalen v. Roe*, 429 U.S. 589, 603 (1977) (emphasis added). Treatment may be necessary to prolong life, to alleviate pain, or to overcome any other maladies which might hinder an individual's capacity to work or to engage in social activities. These benefits undoubtedly comport with the Constitution's life-enhancing objectives.

In addition, this Court has recognized an interest "in avoiding the unwanted administration of . . . drugs". *Washington v. Harper*, 494 U.S. 210, 221-22 (1990). This interest also relates to constitutional objectives by directly implicating the freedom to move about in society unimpeded by the intrusive restraint of a technological apparatus or the forced ingestion of pills or medication. *See Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 269, 278, 279 (1990) (referring to an interest in avoiding unwanted bodily intrusions).

To the extent that a decision to accept or refuse treatment implicates hastened death, this Court has permitted the states to limit the decision maker's discretion. Thus, the states may "prohibit entirely the use of particular drugs" deemed dangerous to the patient's health and safety (*Whalen*, 429 U.S. at 603), and may consider such "dramatic consequences" as death when weighing the policy implications of refusing treatment. *Cruzan*, 497 U.S. at 279. Far from endorsing in these cases any principle that would support the creation of a right to purposely cause death, the Court has permitted the states to circumscribe the right to accept or refuse treatment in direct proportion to the likelihood that

death will result.

Fundamental rights are protected because they enable individuals to live freely and interact socially, even if at times their exercise involves personal risk.[5] The rights to speak, vote, travel, refuse treatment, and so on, could be equated to assisted suicide only by irrebuttably imputing to the citizen who chooses to exercise them in risky situations an inherent desire to be harmed — and by falsely imputing to the Constitution's framers the intent to recognize death as simply another noble objective.

Instead, a constitutionally protected decision to purposely seek death would be unique among all other protected choices. It would embrace a lethal purpose, while the exercise of other rights merely tolerate certain residual and unavoidable risks. Its objective is death rather than life, and its exercise results in irreversible alienation rather than social participation. While the "recognition of any right creates the possibility of abuse" (*Compassion in Dying*, 79 F.3d at 831), a constitutional policy favoring assisted suicide eliminates any contingency by endorsing what is itself a form of abuse. Indeed, the abuses of other freedoms — involving threats against life and self-expulsion from society — would frame the essence of this new right. The dangers its constitutional enshrinement would pose for persons with terminal conditions, other vulnerable populations, and society itself would be of a far greater magnitude than the risks created by the exercise of any other right.

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[5]The Supreme Court has noted that "[s]ome cost will be paid by anyone who approves or implements a constitutional decision where it is unpopular, or who refuses to work to undermine the decision or to force its reversal. The price may be criticism or ostracism, or it may be violence." *Casey*, 505 U.S. at 867.

B. *A Constitutional Rule Establishing The Freedom To Renounce Society's Protection Of One's Right To Live Would Ratify The Most Extreme Form Of Social And Political Alienation.*

While the assisted suicide claim before this Court ostensibly concerns individual rights, the Court must also consider the social consequences. In particular, constitutionalizing the right to seek to harm one's self with the assistance of others says just as much about the constitutional status of persons granted this right as it says about the right itself. Thus, the question is broader than "does the life-destroying right to assisted suicide share equal billing with other freedoms that are instead life-enhancing?" The inquiry must also focus on why the right to live of some persons should be slashed in value from an unalienable to an alienable constitutional interest.

The Ninth and Second Circuits tied the strength of one's right to live to one's proximity to death, thereby provoking a profound fear among many of those persons in society whose disabilities leave them with an already precarious hold on life. Every person with a disabling condition is already more intensely aware than most of life's contingent nature, even if his or her present condition is not certifiably terminal. Many persons with disabilities were disabled by accidents and thus have peered through the gates of death before medicine made survival possible. Many persons with disabilities rely on high tech interventions to survive, to breathe or to eat, and they are constantly reminded by the nature of their ongoing care that without proper treatment or care they would soon die. Many persons with disabilities depend on the assistance of family, friends, and professional caregivers and must orchestrate ever-shifting schedules simply to meet the minimum requirements of daily living. Some, like the actor Christopher Reeves, cannot function without substantial medical and personal assistance. Most are far less capable than a wealthy movie star of meeting the financial burdens of their care, however, and few enjoy the same public esteem.

Most members of this class are unquestionably more vulnerable to discrimination and social alienation.

Many persons with disabilities exist in a state of "virtual terminality" because the frailty of their physical condition and the specter of death are so intimately woven together. In turn, a constitutional decision asserting that their right to live is constitutionally disposable makes them "virtual aliens" because their most fundamental right — the protection of life — would hang only by the single thread of their own resolve to keep it. They will be left far less secure against both internal and external pressures to give away this right to the unjust advantage of others.

In the end, a condition-based rule in favor of assisted suicide would pour into the Constitution a poisonous concoction of warm-hearted, misguided pity and cold-hearted utilitarianism. The question of "whether we as a society are willing to excuse the terminally ill for deciding that their lives are no longer worth living" would be mixed inextricably with the question of whether assisted suicide should serve as a means "for housecleaning, cost-cutting and burden shifting — a way to get rid of those whose lives we deem worthless." *Compassion in Dying*, 79 F.3d at 856-57 (Beezer, J., dissenting). Who stands to benefit most from a constitutional policy by which the right to live of vulnerable persons is reduced to an alienable interest? Is it the person with a terminal condition bent on suicide regardless of what the Constitution holds, or is it a cost-conscious society seeking more ways to ration its generosity?

C. *A Constitutional Rule Limiting Assisted Suicide To Persons With Terminal Conditions Offers A False And Dangerous Compromise.*

Proponents of assisted suicide strive to appear moderate and attempt to strike a balance between what they perceive to be extremes on both ends of the spectrum. They claim that, while an across-the-board ban is too restrictive for their

tastes, unrestricted suicide is not their aim. They would agree to the construction of what is, in effect, a brick wall across the slippery slope — supposedly to accommodate both the "hard cases" and society's general abhorrence of intentional killing. The Ninth and Second Circuits extended this call for compromise in the constitutional order by overriding the states' uniform bans against assisted suicide, yet nevertheless recommending the adoption of various legislative safeguards. *Compassion in Dying*, 79 F.3d at 832-33; *Quill*, 80 F.3d at 730.

Such appeals for compromise seek to divide permissible from impermissible suicides according to the victim's proximity to death and quality of life. They assume that the desirability of death can and should be balanced against the desirability of life by referring to a person's physical and mental condition. No matter how desperate for death suicidal individuals may be and no matter how little they may value their own lives, their requests to die will be approved only according to a social, not individual, estimation of the comparative values of their life and death. Through such a calculus, the law and the community would sanction death not because the victim wants it, but because the victim who wants it also happens to have a condition that the law and community identify as unworthy of protection.

Moreover, such a policy would still permit the states to punish suicide assistance when the victim is not terminally ill. The retention of a uniform ban evinces the belief that suicide is a bad thing both for the victim and society, and that the law's protection is a benefit — yet *only* if the victim is healthy and expected to live indefinitely. Because the resulting disparity in the level of protection would create an apartheid based on one's health status, the lower courts' assertion that suicide is a constitutional benefit should be rejected on its face.

Why is it beneficial for persons with terminal conditions but no one else to obtain lethal medications to kill themselves? The question calls for a more compelling response

because one can easily infer from the circumstances an invidious motive.[6] A policy which permits lethal assistance for some, but not for the majority, implicates the view that those provided the lethal assistance are less worthy or deserving of protection, and that their lives have less value under the law. Such a policy would fundamentally alter our country's commitment to providing equal protection to vulnerable persons.

As one commentator has written:

> [Our society's] liberal commitment to limited popular government requires a commitment to the equal worth of each person and to limits on the power of government that are contained in the teaching of inalienable rights, especially an inalienable right to life. This teaching forms the essential horizon of liberal theory and it is only within this horizon that liberal regimes and the policies they endorse can take shape. . . . Given the liberal commitment to equality as the precondition of liberty, the "new consensus" [proposing that certain suicides be sanctioned based on the assumption that some lives are less valuable than others] fails completely in its policy recommendations. The policies these writers wish to see adopted logically entail the creation

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[6]A Florida statute making consensual sexual activity with "chaste" minors a crime but not with "unchaste" minors created a similar invidious inference, according to an opinion found in *B.B. v. State*, 659 So. 2d 256 (Fla. 1995). Florida Supreme Court Justice Kogan asserted that such a law

> seems to regard unchaste minors as being somehow less deserving of the state's protection than those who are [chaste]. . . . Any statute that purports to grant special status to a favored group . . . over all others, to my mind at least, must be regarded as inherently questionable. On its face this statute suggests discrimination. . . . Laws should protect everyone, not merely a favored group.

Id. at 260-61 (Kogan, J., concurring).

> of a public standard for determining when some lives are in fact not worth living anymore. However, this is a judgment that is fundamentally inconsistent with the premises of the very regime that is supposed to adopt this policy.

Richard Sherlock, *Suicide and Public Policy: A Critique of the "New Consensus"*, 4 Journal of Bioethics 58, 62 (1982-83).

For this reason, the law should not abandon whole categories of the most vulnerable individuals under the guise of protecting individual rights. Instead, as concluded by the British Medical Association,

> the deliberate taking of a human life should remain a crime. This rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy. It is instead, an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel.

British Medical Association, *Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia* 69 (1988).

This Court has assured the Nation that "while the Constitution protects against invasions of individual rights, it is not a suicide pact." *Haig v. Agee*, 453 U.S. 280, 309 (1981) (quoting *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 160 (1963)). Consistent with this assurance, this Court should reject the Ninth and Second Circuit rulings.

CONCLUSION

For the foregoing reasons, the judgments of the Ninth and Second Circuits should be reversed.

ing *Kennedy v. Mendoza-Martinez*, 372 U.S. 144, 160 (1963)). Consistent with this assurance, this Court should reject the Ninth and Second Circuit rulings.

CONCLUSION

For the foregoing reasons, the judgments of the Ninth and Second Circuits should be reversed.

Respectfully submitted,

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Nos. 95-1858 and 96-110

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF *AMICUS CURIAE* ON BEHALF OF MEMBERS OF THE NEW YORK AND WASHINGTON STATE LEGISLATURES IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE AMICI	1
SUMMARY OF ARGUMENT	2
ARGUMENT	4
I. THE LIBERTY LANGUAGE OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS ONLY THAT CONDUCT WHICH IS IMPLICIT IN THE CONCEPT OF ORDERED LIBERTY AND WHICH, HISTORICALLY AND TRADITIONALLY, IS CONSIDERED BEYOND THE POWER OF THE STATE TO PROHIBIT	4
II. THE COMMON LAW OF ENGLAND, AS RECEIVED BY THE AMERICAN COLONIES, PROHIBITED SUICIDE AND ATTEMPTED SUICIDE	8
III. ALTHOUGH THE PENALTIES FOR SUICIDE AND ATTEMPTED SUICIDE ULTIMATELY FELL INTO DISFAVOR IN AMERICAN LAW, THE STATES HAVE RETAINED A STRONG AND COMPELLING INTEREST IN THE PRESERVATION OF HUMAN LIFE AND IN THE PREVENTION OF SUICIDE	15
IV. BOTH THE SECOND CIRCUIT AND THE NINTH CIRCUIT ERRED IN EQUATING SUICIDE WITH THE REFUSAL OF UNWANTED LIFE-SUSTAINING MEDICAL TREATMENT	23
CONCLUSION	30
APPENDIX—List of the Amici	1a

TABLE OF AUTHORITIES

Cases: Page

Barber v. Superior Court, 195 Cal. Rptr. 484 (Ct. App. 1983) 26
Bartling v. Superior Court, 209 Cal. Rptr. 220 (Ct. App. 1984) 26
Benard v. Protected Home Circle, 146 N.Y.S. 232 (App. Div. 1914) 16
Bigelow v. Berkshire Life Ins. Co., 93 U.S. 284 (1876) 16
Blackburn v. State, 23 Ohio St. 146 (1872) 20
Bohaker v. Travelers Ins. Co., 102 N.W. 342 (Mass. 1913) 16
Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Ct. App. 1986) 26
Bowers v. Hardwick, 478 U.S. 186 (1986) 6
Brophy v. New England Sinai Hospital, Inc., 497 N.E.2d 626 (Mass. 1986) 27
Brown v. Metropolitan Life Ins. Co., 7 N.W.2d 21 (Iowa 1943) 16
Campbell v. Supreme Conclave Improved Order Heptasophs, 49 A. 550 (N.J. 1901) 16
Chanslor v. State, 697 S.W.2d 393 (Tex. Cr. App. 1985) 21
Collins v. City of Harker Heights, Texas, 503 U.S. 115 (1992) 5
Commonwealth v. Bowen, 13 Mass. 356 (1816) 18
Commonwealth v. Hicks, 82 S.W. 265 (Ky. 1904) 18
Commonwealth v. Mink, 123 Mass. 422 (1877) 16, 18
Commonwealth v. Swartzentruver, 389 A.2d 181 (Pa. Super. 1978) 21
Commonwealth v. Wright, 11 Pa. D. 144 (Ct. Quarter Sess., Phil. County 1902) 14
Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) ..... *passim*
Compassion in Dying v. State of Washington, 85 F.3d 1440 (9th Cir. 1996) 9, 25
Connecticut Mut. Life Ins. Co. v. Groom, 86 Pa. 92 (1878) 14, 19
Crook v. State, 160 So.2d 884 (Ala. 1963) 17
Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261 (1990) ..... *passim*

TABLE OF AUTHORITIES—Continued

Page

De Grella by and through Parrent v. Elston, 858 S.W.2d 698 (Ky. 1993) 27
Dickerson v. Northwestern Mut. Life Ins. Co., 65 N.E. 694 (Ill. 1902) 16
Dugan v. Commonwealth, 333 S.W.2d 755 (Ky. 1960) 16
Edinburgh v. State, 896 P.2d 1176 (Okla. Cr. App. 1995) 22
Eichner v. Dillon, 426 N.Y.S.2d 517 (App. Div. 1980), *aff'd as modified sub nom. In re Storar*, 420 N.E.2d 64 (N.Y. 1981) 22
Elwood v. New England Mut. Life Ins. Co., 158 A. 257 (Pa. 1931) 14, 16
FCC v. Beach Communications, Inc., 508 U.S. 307 (1993) 27
Fosmire v. Nicoleau, 551 N.E.2d 77 (N.Y. 1990) 26
Gentry v. State, 625 N.E.2d 1268 (Ind. App. 1994) 22
Gilbert v. State, 487 So.2d 1185 (Fla. Dist. Ct. App. 1986), *rev. denied*, 494 So.2d 1150 (Fla. 1986) 22
Gladden v. State, 330 A.2d 176 (Md. 1974) 18
Goodin v. State, 726 S.W.2d 956 (Tex. Cr. App. 1987) 22
Gospodareck v. State, 666 So.2d 835 (Ala. Cr. App. 1993) 22
Grand Lodge of Illinois, Indep. Order of Mut. Aid v. Wieting, 48 N.E. 59 (Ill. 1897) 16
Guardianship of Doe, 583 N.E.2d 1263 (Mass. 1992), *cert. denied sub nom. Doe v. Gross*, 503 U.S. 950 (1992) 27
Hale v. Life Indemnity & Investment Co., 63 N.W. 1108 (Minn. 1895) 16
Hales v. Petit, 1 Plowd. 253, 75 Eng. Rep. 387 (Queen's Bench 1561-1562) 12
Hinson v. State, 709 S.W.2d 106 (Ark. App. 1986) 21
In re Application of Keddie, 1990 WESTLAW 96595 (Del. Super. 1990) 21

TABLE OF AUTHORITIES—Continued

	Page
In re Colyer, 660 P.2d 738 (Wash. 1983)	26
In re Estate of Longeway, 549 N.E.2d 292 (Ill. 1989)	27
In re Farrell, 529 A.2d 404 (N.J. 1987)	27
In re Fiori, 673 A.2d 905 (Pa. 1996)	27
In re Gardner, 534 A.2d 947 (Me. 1987)	27
In re Guardianship of Browning, 568 So.2d 4 (Fla. 1990)	26
In re Guardianship of Grant, 747 P.2d 445 (Wash. 1987), *modified*, 757 P.2d 534 (Wash. 1988)	27
In re Joseph G., 667 P.2d 1176 (Cal. 1983)	21
In re Lawrance, 579 N.E.2d 32 (Ind. 1991)	27
In re L.W., 482 N.W.2d 60 (Wis. 1992)	27
In re P.V.W., 424 So.2d 1015 (La. 1982)	27
In re Quinlan, 355 A.2d 647 (N.J. 1976), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976)	25
In re Rosebush, 491 N.W.2d 633 (Mich. App. 1992)	27
In re Thomas C., 228 Cal. Rptr. 430 (Ct. App. 1986)	22
John Hancock Mut. Life Ins. Co. v. Moore, 34 Mich. 41 (1876)	18
Leach v. Akron General Medical Center, 68 Ohio Misc. 1 (1980)	27
Life Ass'n of America v. Waller, 57 Ga. 533 (1876)	13, 16, 18
Manhattan Life Ins. Co. v. Beard, 66 S.W. 35 (Ky. 1902)	16
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McMahan v. State, 53 So. 89 (Ala. 1910)	16, 17
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Palko v. Connecticut, 302 U.S. 319 (1937)	6, 23

TABLE OF AUTHORITIES—Continued

	Page
Patterson v. Natural Premium Mut. Life Ins. Co., 75 N.W. 980 (Wis. 1898)	16
Pennsylvania Mut. Life Ins. Co. v. Cobbs, 123 So. 94 (Ala. App. 1929)	16
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Regina v. Burgess, 9 Cox. Crim. Cas. 247, 169 Eng. Rep. 1387 (1862)	13
Regina v. Doody, 6 Cox Crim. Cas. 463 (1854)	13
Regina v. Gaylor, 1 Dears. & B. 288, 169 Eng. Rep. 1011 (1857)	12
Regina v. Jessop, 16 Cox Cr. Cas. 204 (1887)	12

TABLE OF AUTHORITIES—Continued

	Page
Regina v. Moore, 3 Car. & K. 319, 175 Eng. Rep. 571 (1852)	13
Regina v. Stormonth, 61 J.P. 729 (1897)	12
Reno v. Flores, 507 U.S. 292 (1993)	5
Rex v. Abbott, 67 J.P. 151 (1903)	12
Rex v. Dyson, Russ. & Ry. 523, 168 Eng. Rep. 930 (1823)	12
Rex v. Mann, 2 K.B. 107, 83 L.J.K.B. 648 (1914)	13
Roe v. Wade, 410 U.S. 113 (1973)	6, 7
Rodriguez v. British Columbia (Attorney General), [1993] 3 S.C.R. 519	29-30
Satz v. Perlmutter, 362 So.2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980)	26-27
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State v. Carney, 55 A. 44 (N.J. 1903)	15, 16
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State v. Jones, 67 S.E. 160 (S.C. 1910)	20
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State v. Levelle, 13 S.E. 319 (S.C. 1891)	16, 20
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State v. Marti, 290 N.W.2d 570 (Ia. 1980)	21
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TABLE OF AUTHORITIES—Continued

	Page
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Wackwitz v. Roy, 418 S.E.2d 861 (Va. 1992)	14, 19
Wallace v. State, 116 N.E.2d 100 (Ind. 1953)	16
Wyckoff v. Mut. Life Ins. Co. of N.Y., 147 P.2d 227 (Or. 1944)	16

Statutes:

Alabama:

ALA. DIGEST, tit. 17, ch. 1, § 45, at 214 (H. Toulmin ed. 1823)	17
PENAL CODE, No. 138, ch. 3, § 2, 1840-41 Ala. Acts 122 (*codified as* Supplement to AIKEN'S DIGEST PENAL CODE, ch. 3, § 2, at 210 (A. Meek ed. 1836-41)	17
ALA. CODE § 13A-3-24(4) (1994)	21
ALA. CODE § 13A-6-3 (1994) and *Commentary*	17
ALA. CODE § 22-8A-10 (1990)	24

Alaska:

ALASKA STAT. § 11.41.120(a)(2) (Michie 1989)	19
ALASKA STAT. § 11.81.430(a)(4) (Michie 1989)	21
ALASKA STAT. § 18.12.080(f) (Michie 1994)	24

Arizona:

ARIZ. REV. STAT. ANN. § 13-403(4) (West 1989)	21
ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (West Supp. 1995)	19
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TABLE OF AUTHORITIES—Continued

Page

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ARK. CODE ANN. § 5-2-605(4) (Michie 1993) 21
ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1993) .. 19
ARK. CODE ANN. § 20-17-210(g) (Michie 1991) 24

California:

CAL. HEALTH & SAFETY CODE § 7191.5(g) (West Supp. 1996) 24
CAL. PENAL CODE § 401 (West 1988) 19

Colorado:

COLO. REV. STAT. § 15-18-112(1) (West 1987) 24
COLO. REV. STAT. § 18-1-703(1)(d) (West 1990) .. 21
COLO. REV. STAT. § 18-3-104(1)(b) (West Supp. 1995) 19

Connecticut:

CONN. GEN. STAT. ANN. § 19a-575 (West Supp. 1996) 25
CONN. GEN. STAT. ANN. § 53a-18(4) (West 1994) .. 21
CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West 1994) 19

Delaware:

DEL. CONST. art. 1, § 15 (1792) 14
Act of July 12, 1982, § 3, 63 Del. Laws 821 (1981) .. 25
DEL. CODE ANN. tit. 11, § 467(e) (1995) 21
DEL. CODE ANN. tit. 11, § 645 (1995) 19

Florida:

Act of Aug. 6, 1868, ch. 1637 (No. 13), subchap. 3, § 9, 1868 Fla. Laws 61, 64 17
FLA. STAT. ANN. § 765.309(1) (West Supp. 1996) .. 24
FLA. STAT. ANN. § 782.08 (West 1992) 19

Georgia:

GA. CODE ANN. § 16-5-5(b) (1996) 19
GA. CODE ANN. § 31-32-11(b) (1996) 24

Hawaii:

HAW. REV. STAT. § 327D-13 (Supp. 1992) 24
HAW. REV. STAT. § 703-308(1) (1985) 21

TABLE OF AUTHORITIES—Continued

Page

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IDAHO CODE § 18-303 (1987) 20
IDAHO CODE § 39-152 (Supp. 1996) 25

Illinois:

ILL. COMP. STAT. ANN. ch. 720, § 5/12-31(a)(2) (Smith-Hurd Supp. 1996) 19-20
ILL. COMP. STAT. ANN. ch. 755, § 35/9(f) (Smith-Hurd 1992) 24
ILL. COMP. STAT. ANN. ch. 755, § 40/50 (Smith-Hurd 1992) 25

Indiana:

IND. CODE ANN. § 16-36-1-12(c) (Michie 1993) 25
IND. CODE ANN. § 16-36-1-13 (Michie 1993) 25
IND. CODE ANN. § 16-36-4-19 (Michie 1993) 24
IND. CODE ANN. § 30-5-5-17(b) (Michie Supp. 1996) 25
IND. CODE ANN. § 35-42-1-2.5(b) (Michie Supp. 1996) 20

Iowa:

IOWA CODE ANN. § 144A.11.6 (West 1989) 24
IOWA CODE ANN. § 144B.12.2 (West Supp. 1996) 25
Iowa S.F. 2066, *to be codified as* IOWA CODE ANN. § 707A.2 20

Kansas:

KAN. TERR. STAT. ch. 48, § 8 (1855) 17
KAN. STAT. ANN. § 21-3406 (1995) 20
KAN. STAT. ANN. § 65-28,109 (1992) 24

Kentucky:

KY. REV. STAT. ANN. § 216.302 (Michie 1995) 20
KY. REV. STAT. ANN. § 311.639 (Michie 1995) 24
KY. REV. STAT. § 503.100(1)(a) (Michie 1990) 21

Louisiana:

LA. REV. STAT. ANN. § 14:32.12 (West Supp. 1996) 20
LA. REV. STAT. ANN. § 40:1299.58.10(A) (West 1992) 24

TABLE OF AUTHORITIES—Continued

Page

Maine:

ME. REV. STAT. ANN. tit. 17-A, § 106(6) (West 1983) 21
ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1983) .. 20
ME. REV. STAT. ANN. tit. 18-A, § 5-813(c) (West Supp. 1995) 24

Maryland:

MD. CONST., Declaration of Rights § 24 (1776) 14
MD. HEALTH-GEN. CODE ANN. § 5-611(c) (1994) 24

Massachusetts:

MASS. GEN. LAWS ANN. LAW, ch. 201D, § 12 (West Supp. 1996) 25

Michigan:

CASS CODE of 1816, Crimes § 58, *reprinted in* 1 MICH. TERR. LAWS 132-33 (1871) 18
MICH. COMP. LAWS ANN. § 700.496(20) (West 1995) 25
MICH. COMP. LAWS ANN. § 750.505 (West 1991) 18

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MINN. STAT. ANN. § 145B.14 (West Supp. 1996) .. 24
MINN. STAT. ANN. § 609.06(8) (West 1987) 21
MINN. STAT. ANN. § 609.215 (West 1987 and Supp. 1996) 20

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MISS. CODE ANN. § 41-41-117(2) (1993) 24
MISS. CODE ANN. § 97-3-49 (1994) 20

TABLE OF AUTHORITIES—Continued

Page

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MO. ANN. STAT. § 459.055(5) (West 1992) 24
MO. ANN. STAT. § 563.061(5) (West 1979) 21
MO. ANN. STAT. § 565.023.1(2) (West Supp. 1996) .. 20

Montana:

MONT. CODE ANN. § 45-5-105 (1995) 20
MONT. CODE ANN. § 50-9-205(7) (1995) 24

Nebraska:

NEB. REV. STAT. ANN. § 20-412(7) (Michie 1995) .. 24
NEB. REV. STAT. ANN. § 28-307 (Michie 1995) 20
NEB. REV. STAT. ANN. § 28-1412(7) (Michie 1995) .. 21

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Crimes & Punishments Act of 1911, § 115, *codified as* NEV. REV. LAWS § 6380 (1912), *repealed by* an Act of Mar. 25, 1913, ch. 238, § 1, 1913 Nev. Stat. 362, 362 15
Act of Mar. 4, 1957, ch. 35, § 1, 1956-57 Nev. Stat. 59, 59-60, *repealed by* an Act of Mar. 31, 1961, ch. 256, § 1, 1961 Nev. Stat. 416, 416 15
NEV. REV. STAT. ANN. § 449.670(2) (Michie 1991) .. 24

New Hampshire:

N.H. CONST. pt. 2, art. 89 (adopted 1789) 14
N.H. REV. STAT. ANN. § 137-H:13 (1996) 24
N.H. REV. STAT. ANN. § 627:6(VI) (1996) 21
N.H. REV. STAT. ANN. § 630.4 (1996) 20

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N.J. CONST. of 1776, art. 17 14
Act of May 9, 1957, ch. 34, § 1, 1 N.J. Laws 63, 67 (1957), *codified as* N.J. REV. STAT. § 2A:170-25.6 (Supp. 1967), *repealed by* an Act of Feb. 16, 1972, ch. 450, § 3, 1971 N.J. Laws 1934 15
N.J. STAT. ANN. § 2C:3-7(e) (West 1995) 21
N.J. STAT. ANN. § 2C:11-6 (West 1995) 20

TABLE OF AUTHORITIES—Continued

	Page
N.J. STAT. ANN. § 26:2H-54(d) (West 1996)	25
N.J. STAT. ANN. § 26:2H-54(e) (West 1996)	25
New Mexico:	
N.M. STAT. ANN. § 24-7A-13(C) (Michie Supp. 1995)	25
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N.Y. PENAL LAW § 35.10(4) (McKinney 1987)	21
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N.Y. PENAL LAW § 125.15(3) (McKinney 1987)	20
N.Y. PUB. HEALTH LAW § 2989(3) (McKinney 1993)	25
North Carolina:	
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N.C. Laws, ch. V, § II (1778), *reprinted in* 1 THE FIRST LAWS OF THE STATE OF NORTH CAROLINA (John D. Cushing ed. 1984)	19
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TABLE OF AUTHORITIES—Continued

	Page
N.D. CENT. CODE § 12.1-05-05(5) (1985)	21
N.D. CENT. CODE § 12.1-16-04 (Supp. 1995)	20
N.D. CENT. CODE § 23-06.4-01 (1991)	24
N.D. CENT. CODE § 23-06.5-01 (1991)	25
Ohio:	
OHIO REV. CODE ANN. § 2133.12(D) (Anderson Supp. 1995)	24
Oklahoma:	
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OKLA. STAT. ANN. tit. 21, § 815 (West 1983)	20
OKLA. STAT. ANN. tit. 63, § 3101.12(G) (West Supp. 1996)	24
Oregon:	
OR. GEN. LAWS 1845-1864 (Deady 1866), Code of Crim. Proc. § 508 at 528	17
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OR. REV. STAT. § 161.205(4) (1993)	21
OR. REV. STAT. § 163.125(1)(b) (1993)	20
Pennsylvania:	
PA. CONS. STAT. ANN. tit. 18, § 508(d) (West 1983)	21
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THE EARLIEST ACTS AND LAWS OF THE COLONY OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, 1647-1719 (John D. Cushing ed. 1977)	14
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TABLE OF AUTHORITIES—Continued

	Page
R.I. Pub. Act 96-113, *to be codified as* R.I. GEN. STAT. tit. 11, ch. 60	20
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R.I. GEN. LAWS § 23-4.11-10(f) (Supp. 1995)	24
South Carolina:	
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S.C. Acts, No. 253, § VI (Apr. 9, 1706), *reprinted in* 1 THE EARLIEST PRINTED LAWS OF SOUTH CAROLINA, 1692-1734 (John D. Cushing ed. 1978)	14
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S.D. CODIFIED LAWS ANN. § 22-16-37 (Michie 1988)	20
S.D. CODIFIED LAWS ANN. § 34-12D-20 (Michie 1994)	24
Tennessee:	
TENN. CODE ANN. § 39-11-613 (1991)	21
TENN. CODE ANN. § 39-13-216 (Supp. 1995)	20
Texas:	
TEX. HEALTH & SAFETY CODE ANN. § 672.020 (West 1992)	24
TEX. PENAL CODE ANN. § 9.34(a) (West 1994)	21
TEX. PENAL CODE ANN. § 22.08 (West 1994)	20
Utah:	
UTAH CODE ANN. § 75-2-1118 (1993)	24

TABLE OF AUTHORITIES—Continued

	Page
Vermont:	
VT. STAT. ANN. tit. 1, § 271 (1996)	20
Virginia:	
Act of Mar. 14, 1848 (Criminal Code), tit. II, ch. XI, §§ 23, 25, 1847-48 Va. Laws 124	14
VA. CODE ANN. § 18.2-16 (Michie 1996)	19
VA. CODE ANN. § 54.1-2990 (Michie 1994)	24
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WASH. REV. CODE ANN. § 9A.36.060 (West 1988)	20
WASH. REV. CODE ANN. § 70.122.100 (West Supp. 1996)	24
WASH. REV. CODE ANN. § 71.05.020 (West 1992)	22
West Virginia:	
W. VA. CODE § 16-30-10 (1995)	24
Wisconsin:	
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WIS. STAT. ANN. § 154.11(6) (West 1989)	24
WIS. STAT. ANN. § 939.48(5) (West 1996)	21
WIS. STAT. ANN. § 940.12 (West 1996)	20
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TABLE OF AUTHORITIES—Continued

	Page
I BRITTON, Bk. I, ch. VIII (F. Nicols trans. 1865) (reprinted 1983, W.W. Gaunt)	9-10
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WHEN DEATH IS SOUGHT[:] ASSISTED SUICIDE AND EHTHANASIA IN THE MEDICAL CONTEXT, New York State Task Force on Life and the Law (May 1994)	1, 27-28

INTEREST OF THE AMICI

Amici curiae are New York and Washington state legislators who strongly support the public policy expressed in their state laws prohibiting assisted suicide and who vigorously oppose efforts to legalize assisted suicide in the legislatures or the courts. *Amici* firmly believe that there is no social, economic or medical need to permit physician-assisted suicide under any circumstances, and that to allow suicide assistance, even for mentally competent, terminally ill adults, would lead to grave abuses and exploitation of the most vulnerable members of our community, as it already has in the Netherlands. *Amici* fully concur with the warning of the New York State Task Force on Life and the Law that creation of a right to suicide "would carry us into new terrain."

> American society has never sanctioned suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.
>
> WHEN DEATH IS SOUGHT[:] ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT vii-viii (May 1994).

This Court should heed their warning and not recognize a right to suicide or suicide assistance.*

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* This Brief is filed with the consent of the parties. Letters of consent have been lodged with the Clerk of the Court.

SUMMARY OF ARGUMENT

In a pair of unprecedented opinions, the Second Circuit and the Ninth Circuit have held that New York and Washington are powerless to prevent mentally competent, terminally ill patients from intentionally ending their lives with the assistance of physicians who are willing to prescribe lethal drugs for them. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996); *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996). In recognizing a right to commit suicide with the assistance of third parties, the *en banc* majority in *Compassion in Dying* swept aside a uniform tradition of legal and societal opposition to suicide and assisted suicide that dates back to the earliest days of the common law. Contrary to the Ninth Circuit's opinion, nothing in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), required or allowed the court of appeals to ignore this history in evaluating plaintiffs' wholly novel constitutional claim.

Compounding this error, both the Ninth Circuit and the Second Circuit seriously misread this Court's decision in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). Both courts attempted to derive an interest in deliberately inducing death, which the law always has treated as a crime, from the interest in refusing unwanted medical treatment, which the law traditionally has protected out of respect for the inviolability of the human person. Disregarding critical distinctions between *intending* a result and *knowing* that a result is likely, and between *causing* death artificially and *allowing* death to occur naturally, the lower courts reasoned that because refusing life-sustaining treatment and intentionally ingesting a fatal dose of drugs both result in a person's death, the right to do the former necessarily entails the right to do the latter. *Quill*, 80 F.3d at 725-31; *Compassion in Dying*, 79 F.3d at 820-24. "But constitutional law does not work that way." *Cruzan*, 497 U.S. at 286.

At the outset, *amici* note that this Court has never held that "a competent person has a constitutionally protected liberty interest" in refusing "life-sustaining medical treatment." *Cruzan*, 497 U.S. at 278, 279. In *Cruzan*, the Court *assumed*, for purposes of deciding the case, that the Constitution "would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279. Nevertheless, the Court cautioned that "the dramatic consequences involved in the refusal of such treatment would inform the inquiry as to whether the deprivation of that interest is constitutionally permissible," *id.*, thereby implying that the State's "interest in the protection and preservation of human life," *id.* at 280, might be sufficient to outweigh the patient's interest in refusing unwanted treatment. That implication was made explicit when the Court said, "We do not think that a State is required to remain neutral in the face of an informed and voluntary decision by a physically able adult to starve to death." *Id.*

Even if it is assumed that a competent person has a constitutionally protected liberty interest in refusing life-sustaining treatment, that interest has its origins in the law of battery and the doctrine of informed consent (*see Cruzan*, 497 U.S. at 269-77) which both define its nature and limit its scope. The interest restricts "governmental power to mandate medical treatment or bar its rejection," *Casey*, 505 U.S. at 857, but does not confer a right to insist upon a particular form of treatment, much less one that will cause, and is intended to cause, the person's death. *See United States v. Rutherford*, 442 U.S. 544 (1979) (FDA had authority to proscribe laetrile, even for terminally ill cancer patients). It is the source and the nature of the interest that determine its ultimate reach. Whether the constitutionally protected interest in refusing unwanted medical treatment extends to life-sustaining treatment, a question this Court need not answer here, that interest clearly has reached its furthest

limit when all treatment—life-sustaining or otherwise—has been withheld or withdrawn.

Beyond their multiple errors in analysis, however, the decisions in both *Compassion in Dying* and *Quill* are, in principle, illimitable. If the right to refuse unwanted medical treatment is the doctrinal source of a right to assistance in committing suicide, it is apparent that the latter right cannot be confined to mentally competent, terminally ill patients, as the Ninth Circuit admitted. *See* 79 F.3d at 816, 831-32 & n.120. The lower court decisions, if affirmed, would plunge the country into a generation of constitutional conflict over the nature and extent of the "right," a conflict which would cause irreparable damage to the Nation, to the American People and to this Court. *Amici* ask the Court not to take this precipitous step.

ARGUMENT

I. THE LIBERTY LANGUAGE OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS ONLY THAT CONDUCT WHICH IS IMPLICIT IN THE CONCEPT OF ORDERED LIBERTY AND WHICH, HISTORICALLY AND TRADITIONALLY, IS CONSIDERED BEYOND THE POWER OF THE STATE TO PROHIBIT.

The Ninth Circuit held that there is "a constitutionally-protected liberty interest in determining the time and manner of one's own death," or, "in common parlance, . . . a right to die." *Compassion in Dying*, 79 F.3d at 793, 799. The court held further that, in the case of mentally competent, terminally ill patients who wish to end their lives by taking a fatal dose of drugs, this liberty interest outweighs the State's "legitimate and countervailing interests, [including] those that relate to the preservation of human life." *Id.* at 793-94. Conceding that there is no "liberty interest in receiving 'aid in killing oneself,'" as such, the court couched the issue in wider terms, whether there is "a right to die," to determine "the

time and manner of one's death" or to "hasten[] one's death," because "it is the end and not the means that defines the liberty interest." *Id.* at 801-02.

The circuit court's phrasing of the issue disregards this Court's admonition that " '[s]ubstantive due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.' " *Reno v. Flores*, 507 U.S. 292, 302 (1993) (quoting Justice Stevens' opinion for a unanimous Court in *Collins v. City of Harker Heights, Texas*, 503 U.S. 115, 125 (1992)). In *Cruzan*, this Court declined to answer the broad question as to whether there is a "right to die," focusing instead on the narrower question of whether "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." 497 U.S. at 277-78.

Precision in defining the issue is also required here. The issue is not whether there is "a right to die," or "a liberty interest in determining the time and manner of one's death" or in "hastening one's death," *Compassion in Dying*, 79 F.3d at 801-02, but "whether the constitution encompasses a right to commit suicide and, if so, whether it includes a right to assistance." *People v. Kevorkian*, 527 N.W.2d 714, 730 n.47 (Mich. 1994) (rejecting right to suicide), *cert. denied sub nom. Kevorkian v. Michigan*, 115 S.Ct. 1795 (1995), *Hobbins v. Kelley*, 115 S.Ct. 1795 (1995).[1]

This Court has enunciated various standards for evaluating both substantive and procedural due process claims. Due process protects those rights which are "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Snyder v. Massachusetts*, 291 U.S. 97,

[1] ". . . the common definition of 'suicide' is the intentional killing of oneself by any means, and the temporal proximity of death is irrelevant to the threshold inquiry into whether the constitution encompasses such a right." *Id.* at 725 n.27.

105 (1934). Alternatively, due process secures those rights which are "implicit in the concept of ordered liberty" such that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937). In another frequently cited formulation, Justice Powell described fundamental liberties as those liberties which are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland, Ohio*, 431 U.S. 494, 503 (1977).

Regardless of the precise wording, each of these tests requires an examination of our history and traditions to assess whether the right (or interest) being asserted has enjoyed legal and societal protection. *Compare Roe v. Wade*, 410 U.S. 113, 140-41 (1973) (recognizing right to abortion where, in the Court's view, there was no unambiguous tradition of legal and social opposition to abortion in English and American law), *with Bowers v. Hardwick*, 478 U.S. 186, 192-94 & nn. 5-7 (1986) (refusing to recognize fundamental right of adult homosexuals to engage in consensual acts of sodomy where both English and American law clearly prohibited such conduct for centuries). The Court's reliance on historical tradition in *Bowers* coincided with a less expansive view of its authority "to discover new fundamental rights imbedded in the Due Process Clause." 478 U.S. at 194.

As this Brief demonstrates, there has never been a period in English or American history when suicide (or suicide assistance) was regarded as a "fundamental right," a "protected liberty interest" or even a socially tolerated practice. Perhaps anticipating that its historical survey, 79 F.3d at 806-10, would fail to convince this Court that a right to (or an interest in) suicide (or suicide assistance) can be derived from our history and traditions, the Ninth Circuit, citing *Planned Parenthood v. Casey*, concluded that these factors are no longer controlling or even persuasive in evaluating substantive due process claims. 79 F.3d at 804-06. But that conclusion is unwarranted.

First, in reaffirming *Roe*, the Court in *Casey* stressed the importance of the rule of *stare decisis* and the integrity of the Supreme Court as an institution in the constitutional order. 505 U.S. at 845-46, 854-69. Neither consideration lends any support to the establishment of a heretofore unrecognized constitutional right. Moreover, in reaffirming *Roe*, the Court sought to *end* the "national controversy" over whether abortion should remain a protected right, *id.* at 867, not to *begin* an entirely new debate on the nature and extent of a previously unheard of right.[2]

Second, in *Casey*, the Court referred to abortion as "a unique act," and said that "the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." 505 U.S. at 852. If abortion is a "unique act" and "so unique to the law," then *Casey* cannot be cited in support of a liberty interest in committing suicide, which has no affinity with this Court's decisions "afford[ing] constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education," *id.* at 851, which are "deeply rooted in this Nation's history and tradition." *Moore*, 431 U.S. at 503.

Third, in *Casey*, the Court stated that "the essential holding of *Roe* forbids a State from interfering with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." 505 U.S. at 880. But protection of that core interest differs radically from an asserted interest in self-destruction where not health, but death, is the desideratum.

Fourth, in *Roe*, the Court was able to recognize a right to abortion only after holding that the unborn child is not a person within the meaning of the Fourteenth Amendment. 410 U.S. at 156-59. Nothing in *Roe*, how-

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[2] The Court's reluctance to state in *Casey* whether *Roe* had been correctly decided as an original matter, 505 U.S. at 869, 871, severely limits the usefulness of looking to either *Roe* or *Casey* as an unexplored source of unenumerated rights.

ever, or in any other decision of this Court remotely suggests that a seriously ill patient, regardless of condition and prognosis, is not a constitutional "person" whose life the State has the right to protect. *See Cruzan*, 497 U.S. at 282 n.10 (recognizing State's interest).

Finally, an examination of *Casey's* analysis of how substantive due process claims are to be reviewed reveals that history and tradition remain critical. "[A]djudication of substantive due process claims may call upon the Court in interpreting the Constitution to exercise that same capacity which by tradition courts always have exercised: reasoned judgment." 505 U.S. at 849. But exercise of that judgment does not allow the Justices "to invalidate state policy choices with which [they] disagree." *Id.* The Court's reliance in *Casey* on Justice Harlan's dissent in *Poe v. Ullman*, 367 U.S. 497, 542 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds), *Casey* 505 U.S. at 849-50, makes it clear that in evaluating original claims of constitutional right, recourse to our history and traditions is still necessary. Thus, this Court must decide whether "the asserted right to commit suicide arises from a rational evolution of tradition, or whether recognition of such a right would be a radical departure from historical precepts." *People v. Kevorkian*, 527 N.W.2d at 730.

II. THE COMMON LAW OF ENGLAND, AS RECEIVED BY THE AMERICAN COLONIES, PROHIBITED SUICIDE AND ATTEMPTED SUICIDE.

An understanding of the development of the common law crime of suicide in England is critical to any analysis of the status of suicide in American colonial law.[3] More

[3] Much of what follows in this and the following argument draws upon the research set forth in Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone and Thomas J. Balch, *Suicide: A Constitutional Right?*, 24 DUQUESNE L. REV. 1 (1986) (hereinafter, *Marzen*). Although the Ninth Circuit repeatedly cited the *Marzen* article in its historical survey (79 F.3d at 807-10 & nn. 23-24, 27, 33-37, 39-40, 42-44), it misstated many of its findings and ignored its conclusion that "the weight of authority in the United States, from colonial days through at least the 1970's[,] has demonstrated that the predominant attitude of society and the law has been one of opposition to suicide," *Marzen*, 24 DUQUESNE L. REV. at 100. *See Compassion in Dying*, 85 F.3d 1440, 1445 & n.14 (9th Cir. 1996) (O'Scanniain, J., dissenting from order rejecting request for rehearing *en banc* by the full court).

than 700 years ago, the thirtenth-century commentator Bracton wrote, "Just as a man may commit felony by slaying another so he may do so by slaying himself, the felony is said to be done to himself [*felo de se*]." 2 H. de Bracton (c. 1250), ON THE LAWS AND CUSTOMS OF ENGLAND (S. Thorne trans. 1968) 423 (BRACTON). If the suicide was committed to avoid punishment for a crime he had committed, all of his property—real and personal—was forfeited to the King. *Id.* at 366, 423-24. But if "a man slays himself in weariness of life or because he is unwilling to endure further bodily pain . . . he may have a successor, but his movable goods are confiscated. He does not lose his inheritance, only his movable goods." *Id.* at 424. His heirs could inherit his real property (because he had not committed suicide to avoid punishment for committing a crime) but his personal property was confiscated by the Crown. "The principle that suicide of a sane person, for whatever reason, was a punishable felony was thus introduced into English common law." *Marzen*, 24 DUQUESNE L. REV. at 59. But no penalty applied to the suicide of one who was not sane. "[A] madman bereft of reason[,]" "the deranged, the delirious and the mentally retarded" or "one labouring under a high fever" do not commit felony *de se* "nor do such persons forfeit their inheritance or their chattels, since they are without sense and reason and can no more commit an *injuria* or a felony than a brute animal." BRACTON at 424.

Bracton's contemporaries agreed that suicide was a crime at common law. The commentator known as Brit-

ton wrote that "where a man is a felon of himself, his chattels shall be adjudged ours [the King's], as the chattels of a felon, but his inheritance shall descend entire to his heirs." I Britton, Bk. I, ch. VIII (F. Nicols trans. 1865) (reprinted 1983 W.W. Gaunt) 39. Fleta, writing near the end of the thirteenth century, provided a fuller treatment of the subject:

> Just as a man may commit felony in slaying another, so he may in slaying himself; for if one who has lately slain a man or has committed some like act whence felonies arise, conscious of his crime and in fear of judgement, slay himself in any fashion, his goods accrue to the Crown nor may he have any other heir than the lord of the fee. But should anyone slay himself in weariness of life or because he is unable to support some bodily pain, he shall have his son for his heir, but his movable goods will be confiscate. Those, too, who cast themselves down from a height or drown themselves likewise have heirs, provided they have committed no felony. Similarly, madmen and those who are frenzied, childish, deranged or are suffering from high fever, although they kill themselves, do not commit felony or forfeit their inheritance or chattels, because they lack sense and reason. Their wives, moreover, should receive their dowers.

Fleta (c. 1290), Bk. I, ch. XXXIV, "*Of Suicides,*" Publications of the Selden Society, Vol. 72, p. 89 (1955).

In 1628, Sir Edward Coke published his classic INSTITUTES. In his THIRD INSTITUTE, Coke classified suicide as a form of murder. "*Felo de se* is a man or woman, which being *compos mentis,* of sound memory, and of the age of discretion, killeth himself, which being lawfully found by the oath of twelve men, all the goods and chattels of the party so offending are forfeited" E. Coke, THIRD INSTSTUTE OF THE LAWS OF ENGLAND 54 (1644 ed.). Like his predecessors, Coke noted an exception for persons who had killed themselves while insane. "If a man lose his memory by the rage of sickness or infirmity,

or otherwise, and kill himself while he is not *compos mentis,* he is not *felo de se*: for as he cannot commit murder upon another, so in that case he cannot commit murder upon himself." *Id.* According to Coke, a *felo de se* forfeited only his goods and chattels *Id.* at 55.

In 1716, the first edition of William Hawkins' A TREATISE OF THE PLEAS OF THE CROWN was published. Noting that "our Laws have always had . . . an Abhorrence of this Crime," Hawkins' analysis of "Homicide against a Man's own Life" largely followed Coke. Wm. Hawkins, 1 A TREATISE OF THE PLEAS OF THE CROWN (1716) 67-68. Hawkins rejected the prevailing "Notion" that anyone who kills himself must be mentally incompetent, *id.* at 67, and condemned the killing of another person with his consent or at his request, as well as suicide pacts. *Id.* at 68.

In 1736, Sir Matthew Hale's work, HISTORY OF THE PLEAS OF THE CROWN, was published. Like Hawkins, Hale reflected Coke's views on the criminality of suicide at common law. M. Hale, 1 HISTORY OF THE PLEAS OF THE CROWN, Ch. XXXI, "*Concerning homicide and first of self-killing or* felo de se," (1736) at 411-12. In accord with the earlier commentators, Hale stated, "If he lose his memory by sickness, infirmity, or accident, and kills himself he is not *felo de se,* neither can he be said to commit murder upon himself or any other." *Id.* at 412. But Hale doubted whether every suicide could be treated as an insane act. *Id.*

In 1803, Sir Edward East published his PLEAS OF THE CROWN. East described anyone "who wilfully . . . causes his own death" as a "*felo de se.*" E. East, 1 PLEAS OF THE CROWN (1803), ch. V, § 5, at 219 (1972 reprint). Calling suicide "an heinous offence," East said that "he who voluntarily kills himself is with respect to the public as criminal as one who kills another. It is equally an offence against the fundamental law of society, which is protection." *Id.*

Sir William Blackstone summarized the law of *felo de se* in his classic eighteenth century commentaries. Characterizing suicide as "[s]elf-murder," Blackstone reiterated the common law's condemnation of suicide as "among the highest crimes, making it a peculiar species of felony, a felony committed on one's self." 4 Blackstone, COMMENTARIES ON THE LAWS OF ENGLAND 189 (1769). Like Hawkins and Hale, Blackstone criticized the tendency of coroner's juries to find "that the very act of suicide is an evidence of insanity; as if every man who acts contrary to reason, had no reason at all: for the same argument would prove every other criminal *non compos*, as well as the self-murderer." *Id.* Blackstone noted that the punishment for suicide at common law was forfeiture of all of the suicide's personal property and ignominious burial in the public way. *Id.* at 190. These punishments were threatened in the hope that a potential suicide's "care for either his own reputation, or the welfare of his family, would be some motive to restrain him from so desperate and wicked an act." *Id.* Nevertheless, Blackstone recommended that the severity of the law be tempered by the power of the sovereign "to execute mercy in judgment." *Id.*

The condemnation of suicide at common law was not limited to the commentators; it was also expressed by the courts. In a case decided more than 400 years ago, an English court described the "quality of the offence" committed by the suicide as "a degree of murder." *Hales v. Petit*, 1 Plowd, 253, 261, 75 Eng. Rep. 387, 399-400 (Queen's Bench 1561-1562). English courts treated both assisted suicide and suicide pacts as forms of homicide.[4]

[4] *See Vaux's Case*, 4 Co. Rep. 44a, 76 Eng. Rep. 992 (1591); *Rex v. Dyson*, Russ. & Ry. 523, 168 Eng. Rep. 930 (1823); *Regina v. Alison*, 8 Car. & P. 418, 173 Eng. Rep. 557 (1838); *Regina v. Jessop*, 16 Cox Cr. Cas. 204 (1887); *Regina v. Stormonth*, 61 J.P. 729 (1897); *Rex v. Abbott*, 67 J.P. 151 (1903). *See also Regina v. Gaylor*, 1 Dears. & B. 288, 169 Eng. Rep. 1011 (1857).

And at common law, *attempted* suicide was a misdemeanor, punishable by fine and imprisonment.[5]

The sparse records available indicate that this was also the law in colonial America. At least nine of the original thirteen colonies prohibited, and in some cases punished, suicide and attempted suicide,[6] though the common law

[5] *See Regina v. Moore*, 3 Car. & K. 319, 175 Eng. Rep. 571 (1852); *Regina v. Doody*, 6 Cox. Crim. Cas. 463 (1854); *Regina v. Burgess*, 9 Cox Crim. Cas. 247, 169 Eng. Rep. 1387 (1862); *Rex v. Mann*, 2 K.B. 107, 83 L.J.K.B. 648 (1914). In its survey of English law, the Ninth Circuit minimized the clear condemnation of suicide (by the mentally competent) enunciated by Bracton and Coke, 79 F.3d at 808-09, relegated Blackstone to an obscure footnote, *id.* at 809 n.38, ignored the other great commentators who unequivocally condemned suicide as criminal and overlooked at least a dozen English cases expressing the law's (*and* society's) disapproval of suicide. Although, in the case of *completed* suicides, juries may have been reluctant to return a verdict that would result in a property forfeiture that would punish only innocent survivors, the guilty verdicts returned against persons who *attempted* suicide, *assisted* suicide or *survived* suicide pacts strongly suggest that English juries experienced no comparable difficulty in applying the law where no forfeiture was at stake.

[6] *Connecticut:* 2 Z. Swift, A SYSTEM OF LAWS OF THE STATE OF CONNECTICUT 304 (n.p. 1796) (reprinted 1972) (noting early instances of ignominious burials); Booth, Woodruff, Mather, Baldwin & Turrill, *Preface* to CONN. GEN. STAT. at vi (1875) (noting State's adoption of common law of England).

Georgia: Life Ass'n of America v. Waller, 57 Ga. 533, 536 (1876) (suicide "a species of crime or wickedness—something wrong; a kind of self-murder" at common law).

Maryland: Pope v. State, 396 A.2d 1054, 1072-74 (Md. 1978) (adoption of common law); Note, *Criminal Liability of Participants in Suicide:* State v. Williams, 5 MD. L. REV. 324, 325-26 (1941) (reporting unappealed trial court decision treating suicide as a common law crime).

Massachusetts: THE GENERAL LAWS AND LIBERTIES OF MASSACHUSETTS COLONY (1672), *reprinted in* THE COLONIAL LAWS OF MASSACHUSETTS 137 (W. Whitmore ed. 1887) (statute mandating ignominious burial for suicide).

North Carolina: State v. Willis, 121 S.E.2d 854 (N.C. 1961) (suicide a criminal act at common law, attempted suicide punishable

penalties generally were abolished after the Revolution.[7] The penalties were abolished, not because society no longer regarded suicide as a wrong (much less as a right), but because of an awareness that punishment could not reach the suicide and a moral sense that it was unfair to punish the suicide's innocent survivors. *See Cruzan*, 497 U.S. at 294 (Scalia, J., concurring).

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as a misdemeanor). *See also* N.C. Laws, ch. XXXI, § VI (1715), *reprinted in* 1 THE FIRST LAWS OF THE STATE OF NORTH CAROLINA 18 (John D. Cushing ed. 1984) (adopting common law).

Pennsylvania: Connecticut Mut. Life Ins. Co. v. Groom, 86 Pa. 92, 97 (1878) (describing suicide as "the crime of self-murder"); *Commonwealth v. Wright*, 11 Pa. D. 144 (Ct. Quarter Sess., Phil. County 1902) (criticizing practice of indicting persons "for the common law offence of attempting to commit suicide"); *Elwood v. New England Mut. Life Ins. Co.*, 158 A. 257, 259 (Pa. 1931) (classifying attempted suicide as "a crime infamous at common law," and a successful suicide as "a species of felony").

Rhode Island: THE EARLIEST ACTS AND LAWS OF THE COLONY OF RHODE ISLAND AND PROVIDENCE PLANTATIONS, 1647-1719, at 19, 59 (John D. Cushing ed. 1977) (adopting common law punishments for suicide).

South Carolina: S.C. Acts, No. 253, § VI (Apr. 9, 1706), *reprinted in* 1 THE EARLIEST PRINTED LAWS OF SOUTH CAROLINA, 1692-1734, at 192 (John D. Cushing ed. 1978), (recognizing criminality of suicide at common law).

Virginia: A. Scott, CRIMINAL LAW IN COLONIAL VIRGINIA 108 n.198, 198-99 nn.15-16 (1930) (noting instances of ignominious burial and forfeiture of property).

[7] *See, e.g.*, DEL. CONST. art. 1, § 15 (1792); MD. CONST., Declaration of Rights § 24 (1776); N.H. CONST. pt. 2, art. 89 (adopted 1789); N.J. CONST. of 1776, art. 17; N.C. Laws, ch. XXXI (1787), *reprinted in* 2 THE FIRST LAWS OF THE STATE OF NORTH CAROLINA 626 (John D. Cushing ed. 1984); an Act to reform the penal Laws, § 53 (1798), *reprinted in* 2 THE FIRST LAWS OF THE STATE OF RHODE ISLAND 604 (John D. Cushing ed. 1983); Act of Mar. 14, 1848 (Criminal Code), tit. II, ch. XI, §§ 23, 25, 1847-48 Va. Laws 124. Contrary to the understanding of the Ninth Circuit, 79 F.3d at 809, the abolition of common law penalties did *not* mean that suicide had been decriminalized. *See Potts v. Barrett Div., Allied Chem. & Dye Corp.*, 138 A.2d 574, 580 (N.J. Super. 1958); *State v. Willis*, 121 S.E.2d 854 (N.C. 1961); *Wackwitz v. Roy*, 418 S.E.2d 861, 864 (Va. 1992).

III. ALTHOUGH THE PENALTIES FOR SUICIDE AND ATTEMPTED SUICIDE ULTIMATELY FELL INTO DISFAVOR IN AMERICAN LAW, THE STATES HAVE RETAINED A STRONG AND COMPELLING INTEREST IN THE PRESERVATION OF HUMAN LIFE AND IN THE PREVENTION OF SUICIDE.

The common law penalties for suicide were abandoned after the Revolutionary War, and attempted suicide was seldom prohibited[8] and more rarely punised.[9] Nevertheless, suicide was regarded as "*malum in se*" and was often referred to as a "crime," a "wrongful

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[8] At one time or another, eight States prohibited attempted suicide: *Minnesota*: MINN. PENAL CODE, §§ 143, 147 (1885), *codified as* MINN. GEN. STAT. §§ 6428, 6432 (1894), *recodified as* MINN. REV. LAWS, § 4870, *repealed by* an Act of Apr. 20, 1911, ch. 293, § 1, 1911 Minn. Laws 409, 409; *Nevada*: Crimes & Punishments Act of 1911, § 115, *codified as* NEV. REV. LAWS § 6380 (1912), *repealed by* an Act of Mar. 25, 1913, ch. 238, § 1, 1913 NEV. STAT. 362, 362; Act of Mar. 4, 1957, ch. 35, § 1, 1956-57 NEV. STAT. 59, 59-60, *repealed by* an Act of Mar. 31, 1961, ch. 256, § 1, 1961 Nev. Stat. 416, 416; *New Jersey*: Act of May 9, 1957, ch. 34, § 1, 1 N.J. Laws 63, 67 (1957), *codified as* N.J. REV. STAT. § 2A:170-25.6 (Supp. 1967), *repealed by* an Act of Act of Feb. 16, 1972, ch. 450, § 3, 1971 N.J. Laws 1934; *New York*: Act of July 26, 1881, ch. 676, §§ 174, 178, 1881 N.Y. Laws (Vol. 3 Penal Code) at 42-43, *repealed by* an Act of May 5, 1919, ch. 414, § 1, 1919 N.Y. Laws 1193, 1193; *North Dakota*: G. Hand, REV. CODES OF THE TERRITORY OF DAKOTA, PENAL CODE §§ 230, 236 (1877), *repealed by* an Act of Mar. 4, 1967, ch. 108, § 1, 1967 N.D. Sess. Laws 215, 300; *Oklahoma*: Okla. Terr. Stat. 2076 (1890), *repealed by* an Act of Jan. 30, 1976, ch. 6, § 2, 1976 Okla. Sess. Laws 7; *South Dakota*: G. Hand, REV. CODES OF THE TERRITORY OF DAKOTA, PENAL CODE §§ 230, 236 (1877), *recodified as* S.D. CODE, § 13.1903 (1939), *repealed by* an Act of Feb. 17, 1968, ch. 31, § 1, § 13.1901, 1968 S.D. Sess. Laws 47, 47; *Washington*: CRIM. CODE, ch. 249, § 134, 1909 Wash. Laws 11th Sess. 890, 929, codified at REM. & BAL. CODE § 2386 (1910), *repealed by* WASH. CRIM. CODE, 1975, ch. 260, § 9A.92.010(213)-(217) Wash. Laws 817, 866, *codified as* REV. WASH. CODE § 9A.92.010(213)-(217) (1977).

[9] Three courts held that attempted suicide could be charged as a common law crime. *See State v. Carney*, 55 A. 44 (N.J. 1903); *State v. Lafayette*, 188 A. 918 (N.J. Common Pleas 1937); *State v. Willis*, 121 S.E.2d 854 (N.C. 1961).

act," a "grave public wrong," or an act of "moral turpitude," even though it was no longer punishable.[10] Indeed, in a case decided 120 years ago, this Court characterized suicide as "self-murder," and referred to the suicide of a sane person as "an act of criminal self-destruction." *Bigelow v. Berkshire Life Ins. Co.*, 93 U.S. 284, 286 (1876).

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[10] *See, e.g., McMahan v. State*, 53 So. 89, 90-91 (Ala. 1910); *Pennsylvania Mut. Life Ins. Co. v. Cobbs*, 123 So. 94, 97 (Ala. App. 1929); *Life Ass'n of America v. Waller*, 57 Ga. 533, 536 (1876); *Grand Lodge of Illinois, Indep. Order of Mut. Aid v. Wieting*, 48 N.E. 59, 61-62 (Ill. 1897); *Dickerson v. Northwestern Mut. Life Ins. Co.*, 65 N.E. 694, 696 (Ill. 1902); *Wallace v. State*, 116 N.E.2d 100, 101 (Ind. 1953); *Brown v. Metropolitan Life Ins. Co.*, 7 N.W.2d 21, 24 (Iowa 1943); *Manhattan Life. Ins. Co. v. Beard*, 66 S.W. 35, 37 (Ky. 1902); *Dugan v. Commonwealth*, 333 S.W.2d 755, 756 (Ky. 1960); *Commonwealth v. Mink*, 123 Mass. 422, 426, 428-29 (1877); *Bohaker v. Travelers Ins. Co.*, 102 N.W. 342, 344 (Mass. 1913); *Hale v. Life Indem. & Inv. Co.*, 63 N.W. 1108, 1108 (Minn. 1895); *Shipman v. Protected Home Circle*, 67 N.E. 83, 85 (N.Y. 1903); *Benard v. Protected Home Circle*, 146 N.Y.S. 232, 235 (App. Div. 1914); *State v. Willis*, 121 S.E.2d 854, 855-57 (N.C. 1961); *Wyckoff v. Mut. Life Ins. Co. of N.Y.*, 147 P.2d 227, 229 (Or. 1944); *Elwood v. New England Mut. Life Ins. Co.*, 158 A. 257, 258-59 (Pa. 1931); *State v. Levelle*, 13 S.E. 319, 321 (S.C. 1891), *overruled on other grounds, State v. Torrence*, 406 S.E.2d 315 (S.C. 1991); *Phadenhauer v. Germania Life Ins. Co.*, 54 Tenn. (7 Heisk.) 567, 576 (1872); *State ex rel. Swann v. Pack*, 527 S.W.2d 99, 113 (Tenn. 1975), *cert. denied*, 424 U.S. 954 (1975); *Plunkett v. Supreme Conclave, Improved Order of Heptasophs*, 55 S.E. 9, 10-11 (Va. 1906); *Patterson v. Natural Premium Mut. Life Ins. Co.*, 75 N.W. 980, 983 (Wis. 1898).

In its highly selective use of historical materials, the Ninth Circuit ignored twenty-two decisions from sixteen American jurisdictions (most of which were cited in *Marzen*) condemning suicide and, instead, focused on one, isolated New Jersey Supreme Court decision from 1901 which, in *dicta*, appeared to excuse suicide, at least in some instances. *See Compassion in Dying*, 79 F.3d at 809-10 (quoting *Campbell v. Supreme Conclave Improved Order Heptasophs*, 49 A. 550, 553 (N.J.L. 1901)). The court failed to note that later New Jersey opinions expressly rejected *Campbell's* approbation of suicide. *See State v. Carney*, 55 A. 44 (N.J. 1903); *Potts v. Barrett Div., Allied Chem. & Dye Corp.*, 138 A.2d 574, 580 (N.J. Super. 1958).

Regardless of the status of suicide itself, most States prohibited *assisted* suicide. By the time that the Fourteenth Amendment was approved in 1868, at least twenty-one of the then thirty-seven States, including eighteen of the thirty ratifying States, banned assisted suicide, either as a statutory[11] or common law offense.[12] Whatever may have been the common law ra-

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[11] *Arkansas:* Act of Feb. 16, 1838, *printed as* ARK. REV. STAT. ch. XLIV, div. III, art. II, § 4, at 240 (1838); *Florida:* Act of Aug. 6, 1868, ch. 1637 (No. 13), subchap. 3, § 9, 1868 Fla. Laws 61, 64; *Kansas:* KAN. TERR. STAT. ch. 48, § 8 (1855); *Minnesota:* MINN. TERR. REV. STAT. ch. 100, § 9, at 493 (1851); *Mississippi:* Act of Feb. 15, 1839, ch. 66, tit. 3, § 7, 1839 Miss. Laws 102, 112, *codified as* MISS. CODE ch. 64, art. 12, tit. 3, § 7, at 958 (Hutchinson 1849); *Missouri:* Act of Mar. 20, 1835, art. II, *codified as* MO. REV. STAT. CRIMES & PUNISHMENTS, art. II, § 8, at 168 (1835); *New York:* 2 N.Y. REV. STAT. pt. IV, ch. I, tit. I, art. 1, § 7 at 661 (1829); *Oregon:* OR. GEN. LAWS 1845-1864 (Deady 1866), CODE OF CRIM. PROC. § 508 at 528; *South Carolina:* 1 THE EARLIEST PRINTED LAWS OF SOUTH CAROLINA 1692-1734, at 190 (John D. Cushing ed. 1978) (statute condemning suicide as a felony and, by implication, *assisted* suicide); *Wisconsin:* REVISED STAT. OF THE STATE OF WIS. ch. 133, § 9 (Albany, N.Y. 1849), *codified as* REV. STAT. OF WIS. ch. 164, § 9 (1858).

[12] *Alabama:* Alabama adopted the common law of crimes, including the law of homicide. ALA. DIGEST, tit. 17, ch. 1, § 45, at 214 (H. Toulmin ed. 1823); PENAL CODE, No. 138, ch. 3, § 2, 1840-41 ALA. ACTS 122 (*codified as* Supplement to AIKEN'S DIGEST PENAL CODE, ch. 3, § 2, at 210 (A. Meek ed. 1836-41)). For the modern statutory codification of common law crimes, *see* ALA. CODE § 13A-6-3 (1994) and *Commentary*. Since "[e]very murder at common law is murder under our statutes," *McMahan v. State*, 53 So. 89, 90 (Ala. 1910), suicide was a felony even though no punishment could be attached. *Id.* at 90-91 ("intentional self-destruction" is "felo de se"). Accordingly, *assisted* suicide would have been criminal, also. *See also Crook v. State*, 160 So.2d 884, 893 (Ala. 1963): "Suicide is murder at Common Law. . . . An agreement compassing it is a criminal conspiracy. If one of the conspirators dies . . . the survivor—if he contributed to the suicide whether present or not—can legitimately be tried for murder."

Connecticut: Connecticut also adopted the common law of crimes. *See* Booth, Woodruff, Mather, Baldwin & Turrill, *Preface to* CONN. GEN. STAT. at vi (1875). Persuading, provoking or counseling

tionale for prohibiting suicide, the States have retained a strong interest in protecting the lives of their citizens. That interest is currently manifested in several ways.

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another to commit suicide was treated as murder. 2 Z. Swift, A DIGEST OF THE LAWS OF THE STATE OF CONNECTICUT 270 (New Haven 1823).

Georgia: A post-Reconstruction case referred to suicide as "something more than self-sought and self-inflicted death. It is a species of crime or wickedness—something wrong; a kind of self-murder." *Life Ass'n of America v. Waller*, 57 Ga. 533, 536 (1876). This language suggests that *assisted* suicide would have been criminal, too.

Kentucky: In 1904, the Kentucky Court of Appeals held that suicide was a common law felony and that one could be charged and convicted for advising or assisting in the commission of a suicide. *Commonwealth v. Hicks*, 82 S.W. 265 (Ky. 1904).

Maryland: From its earliest days, Maryland adopted the common law of crimes. *See Pope v. State*, 396 A.2d 1054, 1072-74 (Md. 1978) (recognizing common law crime of misprision of felony); *Gladden v. State*, 330 A.2d 176 (Md. 1974) (adopting common law "transferred intent" rule); *State v. Buchanan*, 5 H. & J. 317 (1821) (adopting common law crime of conspiracy). Both suicide and assisted suicide were crimes at common law. An unappealed trial court decision in 1940 upheld the conviction of the survivor of a suicide pact for second-degree murder, essentially holding that active assistance in committing suicide is a form of homicide. *See* Note, *Criminal Liability of Participants in Suicide:* State v. Williams, 5 MD. L. REV. 324 (1941).

Massachusetts: Commonwealth v. Bowen, 13 Mass. 356 (1816) (holding that one prisoner who assisted another prisoner in hanging himself in jail could be charged with murder); *Commonwealth v. Mink*, 123 Mass. 422, 429 (1877) (reviewing cases on suicide and attempted suicide and concluding that while not "technically a felony in this Commonwealth," suicide was nevertheless "unlawful and criminal as *malum in se*," and that "any attempt to commit it is likewise unlawful and criminal").

Michigan: From its earliest days as a territory, Michigan adopted the common law of crimes, in addition to particular statutory crimes. *See* CASS CODE OF 1816, Crimes § 58, *reprinted in* 1 MICH. TERR. LAWS 132-33 (1871). For the modern statutory codification of common law crimes, *see* MICH. COMP. LAWS ANN. § 750.505 (West 1991). In an 1876 decision, the Michigan Supreme Court recognized that the suicide of sane person was a crime at common law. *See John Hancock Mut. Life Ins. Co. v. Moore*, 34

First, almost all of the States (forty-six States) forbid assisted suicide, either by an express statute [13] or by ap-

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Mich. 41, 45 (1876). In *People v. Roberts*, 178 N.W. 690 (Mich. 1920), *overruled in part, People v. Kevorkian*, 527 N.W.2d at 733-39, the Michigan Supreme Court upheld a murder conviction of a man who provided poison to his wife who committed suicide. In *Kevorkian*, the Michigan Supreme Court held that assisted suicide was punishable as a common law crime even in the absence of special legislation. *Id.* at 739.

North Carolina: In 1961, the North Carolina Supreme Court, noting that the State had adopted the common law of crimes (*see* N.C. GEN. STAT. § 14-1(1) (1993)), held that attempted suicide was an indictable misdemeanor. *State v. Willis*, 121 S.E.2d 854 (N.C. 1961). The court expressly held that one who "aids and abets another in . . . self-murder is amenable to the law." *Id.* at 856-57. After independence, North Carolina readopted the common law. *See* N.C. LAWS, ch. V, § II (1778), *reprinted in* 1 THE FIRST LAWS OF THE STATE OF NORTH CAROLINA 351 (John D. Cushing ed. 1984).

Pennsylvania: In 1878, the Pennsylvania Supreme Court defined suicides as "the crime of self-murder" in "legal acceptation and in popular use." *Connecticut Mut. Life Ins. Co. v. Groom*, 86 Pa. 92, 97 (1878). As a State that adopted common law crimes, *assisting* suicide would have been a criminal offense.

Tennessee: Tennessee adopted the common law. *See State v. Alley*, 594 S.W.2d 381, 382 (Tenn. 1980). In 1872, the Tennessee Supreme Court referred to suicide "a crime of the highest grade." *Phadenhauer v. Germania Life Ins. Co.*, 54 Tenn. (7 Heisk.) 567, 576 (1872). Thus, *assisted* suicide also would have been unlawful.

Virginia: Virginia adopted the common law of crimes. *See* A. Scott, CRIMINAL LAW IN COLONIAL VIRGINIA 27 (1930); VA. CODE ANN. § 18.2-16 (1996); *Plunkett v. Supreme Conclave, Improved Order of Heptasophs*, 55 S.E. 9, 11 (Va. 1906) (referring to suicide as a "crime"). *See also Wackwitz v. Roy*, 418 S.E.2d 861, 864 (Va. 1992) ("[s]uicide . . . remains a common law crime in Virginia as it does in a number of other common-law states").

[13] Thirty-five States have enacted statutes banning assisted suicide. ALASKA STAT. § 11.41.120(a)(2) (Michie 1989); ARIZ. REV. STAT. ANN. § 13-1103(A)(3) (West Supp. 1995); ARK. CODE ANN. § 5-10-104(a)(2) (Michie 1993); CAL. PENAL CODE § 401 (West 1988); COLO. REV. STAT. § 18-3-104(1)(b) (Supp. 1995); CONN. GEN. STAT. ANN. § 53a-56(a)(2) (West 1994); DEL. CODE ANN. tit. 11, § 645 (1995); FLA. STAT. ANN. § 782.08 (West 1992); GA. CODE ANN. § 16-5-5(b) (1996); ILL. COMP. STAT. ANN. CH. 720,

plication of general homicide or common law principles.[14] Although suicide assistance is not as common as suicide

§ 5/12-31(a)(2) (Smith-Hurd Supp. 1996); IND. CODE ANN. § 35-42-1-2.5(b) (Michie Supp. 1996); IOWA S.F. 2066, *to be codified as* IOWA CODE § 707A.2 (Supp. 1996); KAN. STAT. ANN. § 21-3406 (1995); KY. REV. STAT. ANN. § 216.302 (Michie 1995); LA. REV. STAT. ANN. § 14:32.12 (West Supp. 1996); ME. REV. STAT. ANN. tit. 17-A, § 204 (West 1983); MINN. STAT. ANN. § 609.215 (West 1987 and Supp. 1996); MISS. CODE ANN. § 97-3-49 (1994); MO. ANN. STAT. § 565.023.1(2) (West Supp. 1996); MONT. CODE ANN. § 45-5-105 (1995); NEB. REV. STAT. ANN. § 28-307 (Michie 1995); N.H. REV. STAT. ANN. § 630.4 (1996); N.J. STAT. ANN. § 2C:11-6 (West 1995); N.M. STAT. ANN. § 30-2-4 (Michie 1994); N.Y. PENAL LAW §§ 120.30, 125.15(3) (McKinney 1987); N.D. CENT. CODE § 12.1-16-04 (Supp. 1995); OKLA. STAT. ANN. tit. 21, §§ 813, 814, 815 (West 1983); OR. REV. STAT. § 163.125(1)(b) (1993) (although Oregon allows physician-assisted suicide under certain circumstances, *see* OR. REV. STAT. § 127.800 *et seq.* (1996), assisted suicide remains generally illegal); PA. CONS. STAT. ANN. tit. 18, § 2505(b) (West 1983); R.I. Pub. Act 96-133, *to be codified as* R.I. GEN. STAT. tit. 11, ch. 60; S.D. CODIFIED LAWS ANN. § 22-16-37 (Michie 1988); TENN. CODE ANN. § 39-13-216 (Supp. 1995); TEX. PENAL CODE ANN. § 22.08 (West 1994); WASH. REV. CODE ANN. § 9A.36.060 (West 1988); WIS. STAT. ANN. § 940.12 (West 1996).

[14] *Idaho:* IDAHO CODE § 18-303 (1987) (adopting common law crimes).

Ohio: Blackburn v. State, 23 Ohio St. 146 (1872) (man convicted of murder for preparing poisonous concoction and giving it to his wife, who drank it intending to kill herself).

South Carolina: State v. Levelle, 13 S.E. 319, 321 (S.C. 1891) ("suicide is an unlawful act, an act *malum in se*, and is a felony"). Since suicide was a felony, *assisted* suicide would have been criminal, also. *See also State v. Jones*, 67 S.E. 160, 162, 165 (S.C. 1910). For the modern statutory codification of common law crimes, *see* S.C. CODE ANN. § 16-1-110 (Law Co-op. Supp. 1995).

Vermont: VT. STAT. ANN. tit. 1, § 271 (1996) (adopting common law). *See State v. Stanislaw*, 573 A.2d 286, 289 (Vt. 1990) (recognizing common law crimes).

West Virginia: State v. General Daniel Morgan Post No. 548, 107 S.E.2d 353, 357 (W. Va. 1959) (adopting common law crimes). For *Alabama, Maryland, Massachusetts, Michigan, North Carolina* and *Virginia, see* the authorities cited in n.12, *supra*.

itself, the States do enforce their assisted suicide laws.[15] Moreover, suicide assistance is often prosecuted as a form of homicide, independent of any assisted suicide statute, where one person actively assists another in killing himself.[16]

Second, nearly one-half of the States allow both private and public actors to use nondeadly force to thwart suicide attempts.[17] Third, all States provide for the tem-

[15] *See, e.g., Hinson v. State*, 709 S.W.2d 106 (Ark. App. 1986); *In re Joseph G.*, 667 P.2d 1176 (Cal. 1983); *In re Application of Keddie*, 1990 WESTLAW 96595 (Del. Super. 1990) (noting plea of guilty to promoting a suicide); *State v. Bauer*, 471 N.W.2d 363 (Minn. App. 1991); *Commonwealth v. Swartzentruver*, 389 A.2d 181 (Pa. Super. 1978); *Chanslor v. State*, 697 S.W.2d 393 (Tex. Cr. App. 1985) (noting that defendant could have been charged with assisted suicide in obtaining poison to give to his wife). *See also Wall Street Journal*, May 1, 1996, A18 (reporting man's plea of guilty to attempted manslaughter for assisting his wife in committing suicide).

[16] *See, e.g., People v. Cleaves*, 280 Cal. Rptr. 146 (Ct. App. 1991) (second degree murder); *State v. Marti*, 290 N.W.2d 570 (Ia. 1980) (involuntary manslaughter); *Persampieri v. Commonwealth*, 175 N.E.2d 387 (Mass. 1961) (involuntary manslaughter); *State v. Bier*, 591 P.2d 1115 (Mont. 1979) (negligent homicide); *State v. Sexson*, 869 P.2d 301 (N.M. 1994) (murder); *People v. Duffy*, 595 N.E.2d 814 (N.Y. 1992) (manslaughter).

[17] See ALA. CODE § 13A-3-24(4) (1994); ALASKA STAT. § 11.81.430(a)(4) (Michie Supp. 1989); ARIZ. REV. STAT. ANN. § 13-403(4) (West 1989); ARK. CODE ANN. § 5-2-605(4) (Michie 1993); COLO. REV. STAT. § 18-1-703(1)(d) (West 1990); CONN. GEN. STAT. ANN. § 53a-18(4) (West 1994); DEL. CODE ANN. tit. 11, § 467(e) (1995); HAW. REV. STAT. § 703-308(1) (1985); KY. REV. STAT. § 503.100(1)(a) (Michie 1990); ME. REV. STAT. ANN. tit. 17-A, § 106(6) (West 1983); MINN. STAT. ANN. § 609.06(8) (West 1987); MO. ANN. STAT. § 563.061(5) (West 1979); NEB. REV. STAT. § 28-1412(7) (Michie 1995); N.H. REV. STAT. § 627:6(VI) (1996); N.J. STAT. ANN. § 2C:3-7(e) (West 1995); N.Y. PENAL LAW § 35.10(4) (McKinney 1987); N.D. CENT. CODE § 12.1-05-05(5) (1985); OKLA. STAT. ANN. tit. 21, § 643(6) (West 1996); Or. Rev. Stat. § 161.205(4) (1993); PA. CONS. STAT. ANN. tit. 18, § 508(d) (West 1983); TENN. CODE ANN. § 39-11-613 (1991); TEX. PENAL CODE ANN. § 9.34(a) (West 1994); WIS. STAT. ANN. § 939.48(5) (West 1996).

porary involuntary commitment of individuals who, as a result of mental disease or illness, may harm themselves.[18] Finally, despite occasional instances of jury nullification or discretionary decisions not to prosecute, acts of "mercy-killing" or active voluntary euthanasia always have been considered as homicide. The law does not accept the consent of the victim as a defense to a charge of homicide,[19] nor benevolent motive as an excuse.[20]

In light of this overwhelming legislative and judicial consensus,[21] which the Ninth Circuit largely ignored, it

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[18] *See, e.g.*, N.Y. MENTAL HYG. LAW, § 9.01 *et seq.* (McKinney 1996); WASH. REV. CODE ANN. § 71.05.020 *et seq.* (West 1992).

[19] *See, e.g., Gospodareck v. Stat*, 666 So.2d 835, 842 (Ala. Cr. App. 1993); *People v. Matlock*, 336 P.2d 505 (Cal. 1959); *In re Thomas C.*, 228 Cal. Rptr. 430 (Ct. App. 1986); *Ragan v. State*, 599 So.2d 276 (Fla. Dist. Ct. 1992); *Gentry v. State*, 625 N.E.2d 1268 (Ind. App. 1994); *State v. Cobb*, 625 P.2d 1133, 1135-36 (Kan. 1981); *State v. Ludwig*, 70 Mo. 412, 415 (1879); *State v. Fuller*, 278 N.W.2d 756, 761 (Neb. 1979); *Edinburgh v. State*, 896 P.2d 1176, 1178-80 (Okla. Cr. App. 1995); *State v. Bouse*, 264 P.2d 800, 812 (Or. 1953), *overruled on other grounds, State v. Fischer*, 376 P.2d 418 (Or. 1962), *State v. Brewton*, 395 P.2d 874 (Or. 1964); *Turner v. State*, 108 S.W. 1139, 1141 (Tenn. 1907); *Goodin v. State*, 726 S.W.2d 956, 957-58 (Tex. Cr. App. 1987); *Martin v. Commonwealth*, 37 S.E.2d 43, 47 (Va. 1946). *See also State v. Mays*, 307 S.E.2d 655 (W. Va. 1983).

[20] *People v. Conley*, 411 P.2d 911, 918 (Cal. 1966) ("one who commits euthanasia bears no ill will toward his victim and believes [that] his act is morally justified . . . nonetheless acts with malice if he is able to comprehend that society prohibits his act regardless of his personal belief"); *Gilbert v. State*, 487 So.2d 1185, 1190 (Fla. Dist. Ct. App. 1986), *rev. denied*, 494 So.2d 1150 (Fla. 1986); *Eichner v. Dillon*, 426 N.Y.S.2d 517, 533 (App. Div. 1980), *aff'd as modified sub nom. In re Storar*, 420 N.E.2d 64 (N.Y. 1981). Anecdotal evidence and polling data that some physicians may assist their patients in killing themselves, *Compassion in Dying*, 79 F.3d at 811 & nn.54-59, does not reflect societal acceptance of such conduct, especially where the conduct is difficult to detect and prosecute.

[21] The Model Penal Code prohibits assisted suicide, even though the Code does not criminalize either suicide or attempted suicide. *See* MODEL PENAL CODE § 210.5(2). In their *Comment*, the drafters said that "the interests in the sanctity of life that are represented by the criminal homicide laws are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." *Id.* at 100.

cannot plausibly be argued that a right to commit suicide (or suicide assistance) under any circumstances is "deeply rooted in this Nation's history and traditions," *Moore v. City of East Cleveland, Ohio*, 431 U.S. at 503, or that it is "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. at 325. It would be "an impermissibly radical departure from existing tradition, and from the principles that underlie that tradition, to declare that there is such a fundamental right protected by the Due Process Clause." *Kevorkian*, 527 N.W.2d at 733.

IV. BOTH THE SECOND CIRCUIT AND THE NINTH CIRCUIT ERRED IN EQUATING SUICIDE WITH THE REFUSAL OF UNWANTED LIFE-SUSTAINING MEDICAL TREATMENT.

The key error of both the Second Circuit's equal protection analysis and the Ninth Circuit's due process analysis was to equate suicide, a crime at common law, with the refusal of unwanted medical care, a right protected by the common law and the Constitution. *See Quill*, 80 F.3d at 725-31; *Compassion in Dying*, 79 F.3d at 820-24. They are not equivalent.

> [W]hereas suicide involves an affirmative act to end a life, the refusal or cessation of life-sustaining treatment simply permits life to run its course, unencumbered by contrived intervention. Put another way, suicide frustrates the natural course by introducing an outside agent to accelerate death, whereas the refusal or withdrawal of life-sustaining medical treatment allows nature to proceed, i.e., death occurs because of the underlying condition.
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> [P]ersons who opt to discontinue life-sustaining medical treatment are not, in effect, committing suicide. There is a difference between choosing a natural death summoned by an uninvited illness or

> calamity, and deliberately seeking to terminate one's life by resorting to death-inducing measures unrelated to the natural process of dying.

People v. Kevorkian, 527 N.W.2d at 728-29.

Virtually without exception, state legislators and both state and federal courts have recognized the distinction between directly *causing* death by an affirmative act ending life and *allowing* death to occur by withholding or withdrawing life-sustaining medical treatment. Forty-seven States expressly disapprove of mercy killing, suicide and assisted suicide in either their natural death acts/living will statutes,[22] or their durable power of attorney for

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[22] ALA. CODE § 22-8A-10 (1990); ALASKA STAT. § 18.12.080(f) (Michie 1994); ARIZ. REV. STAT. ANN. § 36-3210 (West. Supp 1995); ARK. CODE ANN. § 20-17-210(g) (Michie 1991); CAL. HEALTH & SAFETY CODE § 7191.5(g) (West Supp. 1996); COLO. REV. STAT. § 15-18-112(1) (West 1987); FLA. STAT. ANN. § 765.309 (1) (West Supp. 1996); GA. CODE ANN. § 31-32-11(b) (1996); HAW. REV. STAT. § 327D-13 (Supp. 1992); ILL. COMP. STAT. ANN. ch. 755, § 35/9(f) (Smith-Hurd 1992); IND. CODE ANN. § 16-36-4-19 (Michie 1993); IOWA CODE ANN. § 144A.11.6 (West 1989); KAN. STAT. ANN. § 65-28,109 (1992); KY. REV. STAT. ANN. § 311.639 (Michie 1995); LA. REV. STAT. ANN. § 40:1299.58.10(A) (West 1992); ME. REV. STAT. ANN. tit. 18-A, § 5-813(c) (West Supp. 1995); MD. HEALTH-GEN. CODE ANN. § 5-611(c) (1994); MINN. STAT. ANN. § 145B.14 (West Supp. 1996); MISS. CODE ANN. § 41-41-117(2) (1993); MO. ANN. STAT. § 459.055(5) (West 1992); MONT. CODE ANN. § 50-9-205(7) (1995); NEB. REV. STAT. ANN. § 20-412(7) (Michie 1995); NEV. REV. STAT. ANN. § 449.670(2) (Michie 1991); N.H. REV. ANN. § 137-H:13 (1996); N.C. GEN. STAT. § 90-320(b) (1993); N.D. CENT. CODE § 23-06.4-01 (1991); OHIO REV. CODE ANN. § 2133.12(D) (Anderson Supp. 1995); OKLA. STAT. ANN. tit. 63, § 3101.12(G) (West Supp. 1996); PA. CONS. STAT. ANN. tit. 20, § 5402(b) (West Supp. 1996); R.I. GEN. LAWS § 23.4.11-10(f) (Supp. 1995); S.C. CODE ANN. § 44-77-130 (Law. Co-op. Supp. 1996); S.D. CODIFIED LAW ANN. § 32-12D-20 (Michie 1994); TEX. HEALTH & SAFETY CODE ANN. § 672.020 (West 1992); UTAH CODE ANN. § 75-2-1118 (1993); VA. CODE ANN. § 54.1-2990 (Michie 1994); WASH. REV. CODE ANN. § 70.122-100 (West Supp. 1996); W. VA. CODE § 16-30-10 (1995); WIS. STAT. ANN. § 154.11 (6) (West 1989); WYO. STAT. § 35-22-109 (Michie 1994).

health care acts[23] or both.[24]

Moreover, the majority's conclusion in *Compassion in Dying* "that there is no constitutionally permissible distinction between suicide and refusing medical treatment . . . ignores a long line of judicial decisions that recognize the distinction." 85 F.3d at 1444 (O'Scannlain, J., dissenting from order rejecting request for rehearing *en banc* by the full court). In *In re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), the landmark "right-to-die" case, the New Jersey Supreme Court, in authorizing the parents of Karen Ann Quinlan to remove her from a ventilator, was careful to distinguish withdrawal of life support from homicide and suicide "We would see a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, in the fact of irreversible, painful and certain imminent death." *Id.* at 665. The court noted further that "there would be no criminal homicide" in removing the ventilator, explaining that "the ensuing death would not be homicide but rather expiration from existing natural causes." *Id.* at 669-70. In *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417 (Mass. 1977), the Massachusetts Supreme Judicial Court concurred:

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[23] Act of July 12, 1982, § 3, 63 Del. Laws 821 (1981); IDAHO CODE § 39-152 (Supp. 1996) (DNR orders); ILL. COMP. STAT. ANN. ch. 755, § 40/50 (Smith-Hurd 1992); IND. CODE ANN. §§ 16-36-1-12(c), 16-36-1-13 (Michie 1993), *see also* § 30-5-5-17(b) (Michie Supp. 1996); IOWA CODE ANN. § 144B.12.2 (West Supp. 1996); MASS. GEN. LAWS ANN. ch. 201D, § 12 (West Supp. 1996); MICH. COMP. LAWS ANN. § 700.496(20) (West 1995); N.Y. PUB. HEALTH LAW § 2989(3) (McKinney 1993); N.D. CENT. CODE § 23-06.5-01 (1991); R.I. GEN. LAWS 23-4.10-9(f) (Supp. 1995); WYO. STAT. § 3-5-211 (Michie Supp. 1996).

[24] *See* notes 22 and 23, *supra*. *See also* CONN. GEN. STAT. ANN. § 19a-575 (West Supp. 1996) (form declaration); N.J. STAT. ANN. § 26:2H-54(d), -(e) (West 1996) (legislative findings); N.M. STAT. ANN. § 24-7A-13(C) (Michie Supp. 1995).

> In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes, the patient did not set the death producing agent in motion with the intent of causing his own death.

Id. at 426 n.11. *See also Thor v. Superior Court*, 855 P.2d 375, 385 (Cal. 1993) ("a necessary distinction exists between a person suffering from a life-threatening disease or debilitating injury who rejects medical intervention that only prolongs but never cures the affliction and an individual who deliberately sets in motion a course of events aimed at his or her demise and attempts to enlist the assistance of others); *Fosmire v. Nicoleau*, 551 N.E.2d 77, 82 (N.Y. 1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act"); *In re Colyer*, 660 P.2d 738, 743 (Wash. 1983) ("[a] death which occurs after the removal of life sustaining systems is from natural causes, neither set in motion nor intended by the patient").

Almost every court recognizing a right to refuse medical treatment has expressly distinguished removal of life support from suicide, and has drawn a clear distinction between *allowing* death to occur by passive means (refusing life-sustaining treatment) and *causing* death by active means (killing the patient by a direct act that ends his life).[25] No court, with the exception of those courts

[25] *See also Rasmussen v. Fleming*, 741 P.2d 674, 685 (Ariz. 1987); *Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 306 (Ct. App. 1986) (quadriplegic's "decision to let nature take its course is not equivalent to an election to commit suicide with real parties aiding and abetting therein"); *Bartling v. Superior Court*, 209 Cal. Rptr. 220, 225 (Ct. App. 1984); *Barber v. Superior Court*, 195 Cal. Rptr. 484, 487 (Ct. App. 1983); *McConnell v. Beverly Enterprises, Inc.*, 553 A.2d 596, 605 (Conn. 1989); *In re Guardianship of Browning*, 568 So.2d 4, 14 (Fla. 1990) ("suicide is not an issue when . . . the discontinuance of life support 'in fact will merely result in [the patient's] death, if at all, from natural causes'") (citing *Satz v.*

whose decisions are under review here, has held otherwise. As these cases demonstrate, suicide cannot be equated with the refusal of medical treatment. They are different in two key respects: First, in the case of removing life-sustaining treatment, there is no intent to end life, but only the knowledge that death may result. Second, regardless of whether there is an intent to end life, the removal of life support is not the actual cause of death; rather, death results from natural causes (*e.g.*, an underlying pathology that renders a patient unable to breathe or eat without mechanical assistance). These distinctions fully justify treating assisted suicide differently from the refusal of unwanted life-sustaining medical treatment. *See FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313-16 (1993). As the New York State Force Report on Life and the Law noted:

> The imposition of life-sustaining medical treatment against a patient's will requires a direct invasion of bodily integrity and, in some cases, the use of physical restraints, both of which are flatly inconsistent

Perlmutter, 362 So.2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So.2d 359 (Fla. 1980); *In re Estate of Longeway*, 549 N.E.2d 292, 296 (Ill. 1989); *In re Lawrance*, 579 N.E.2d 32, 40 n.4 (Ind. 1991); *De Grella by and through Parrent v. Elston*, 858 S.W.2d 698, 707 (Ky. 1993) ("'[m]ercy killing' and 'euthanasia' or any other 'affirmative or deliberate act to end life' are fundamental violations of the common law") (citation omitted); *In re P.V.W.*, 424 So.2d 1015, 1022 (La. 1982); *In re Gardner*, 534 A.2d 947, 955-56 (Me. 1987); *Guardianship of Doe*, 583 N.E.2d 1263, 1270 (Mass. 1992), *cert. denied sub nom. Doe v. Gross*, 505 U.S. 950 (1992); *Brophy v. New England Sinai Hospital, Inc.*, 497 N.E.2d 626, 638 (Mass. 1986); *In re Rosebush*, 491 N.W.2d 633, 636 n.2 (Mich. App. 1992); *McKay v. Bergstedt*, 801 P.2d 617, 627 (Nev. 1990) ("there is a substantial difference between the attitude of a person desiring non-interference with the natural consequences of his or her condition and the individual who desires to terminate his or her life by some deadly means either self-inflicted or through the agency of another"); *In re Farrell*, 529 A.2d 40, 411 (N.J. 1987); *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 10 (1980); *In re Fiori*, 673 A.2d 905, 910 (Pa. 1996); *In re Guardianship of Grant*, 747 P.2d 445, 455 (Wash. 1987), *modified*, 757 P.2d 534 (Wash. 1988); *In re L.W.*, 482 N.W.2d 60, 71 (Wis. 1992).

> with society's basic conception of personal dignity. . . . It is this right against intrusion—not a general right to control the timing and manner of death—that forms the basis of the constitutional right to refuse life-sustaining treatment. Restrictions on suicide, by contrast, entail no such intrusions, but simply prevent individuals from intervening in the natural process of dying.

WHEN DEATH IS SOUGHT 71.

The decision respondents urge upon this Court not only would overturn the assisted suicide statutes throughout the States, but also would undermine the right of public and private actors to intervene to prevent suicide and jeopardize the authority of public health officials to institutionalize for treatment persons who attempt suicide. Moreover, recognition of a right to suicide assistance could easily lead to the legalization of "homicide by consent." The Ninth Circuit views this possible development with complete equanimity. *Compassion in Dying*, 79 F.3d at 831-32.

Notwithstanding their disclaimers, the right respondents ask this Court to recognize could *not* be limited to mentally competent, terminally ill patients. This is apparent from respondents' reliance upon this Court's abortion jurisprudence and the extensive case law that has developed in support of the right to refuse medical treatment. If abortion jurisprudence is the source of a right to suicide, the States would be powerless to examine the reasons persons would want to kill themselves and then, based on that examination, permit some suicides (the "rational" ones) and forbid others (the irrational ones). *See Casey*, 505 U.S. at 879 ("[the] State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability").

The case law recognizing a right to refuse treatment offers even less reason to believe that a right to suicide (or suicide assistance) could be contained. The right to refuse unwanted medical treatment, including life-sustaining medical treatment, may be exercised *by* persons who are not terminally ill and *for* persons who are not competent. *See* Edward R. Grant and Paul Benjamin Linton, *Relief or Reproach? Euthanasia Rights in the Wake of Measure 16*, 74 OREGON L. REV. 449, 459-61 & nn. 36-39 (1995) (listing cases). A right to assistance in commiting suicide, once established, would inevitably expand to include the incompetent and those who are not terminally ill, as the Ninth Circuit freely acknowledged.[26] *See generally* Grant and Linton, *Relief or Reproach?*, 74 OREGON L. REV. at 516-25 & nn. 293-328.

Only three years ago, the Supreme Court of Canada was asked to legalize the same practice of physician-assisted suicide that respondents urge upon this Court. *See Rodriguez v. British Columbia*, [1993] 3 S.C.R. 519. The Court refused to do so in an opinion that bears careful reading. The prohibition of assisted suicide, the Court stated, "is valid and desirable legislation which fulfills the government's objectives of preserving life and protecting the vulnerable." *Id.* at 590. A "blanket prohibition" of assisted suicide is neither arbitrary nor unfair in the sense of being "unrelated to the state's interest in protecting the vulnerable." *Id.* at 595.

> [The law against assisted suicide] has as its purpose the protection of the vulnerable who might be induced in moments of weakness to commit suicide. This purpose is grounded in the state interest in protecting life and reflects the policy of the state that human life should not be depreciated by allowing life to be taken. This policy finds expression . . . in the provisions of our *Criminal Code* which prohibit

---

[26] *See Compassion in Dying*, 79 F.3d at 816: "Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness." *Id.* at 832 n. 120 ("we should make clear that a decision of a duly-appointed surrogate decision maker is for all legal purposes the decision of the patient himself").

> murder and other violent acts against others notwithstanding the consent of the victim, ...

Id. The Court declined to sanction assisted suicide, even for the terminally ill, because "the active participation by one individual in the death of another is intrinsically morally and legally wrong" and "there is no certainty that abuses can be prevented by anything less than a complete prohibition." *Id.* at 601. "Creating an exception for the terminally ill might . . . frustrate the purpose of the legislation of protecting the vulnerable because adequate guidelines to control abuse are difficult or impossible to develop." *Id.* The law against assisted suicide "may discourage those who consider that life is unbearable at a particular moment, or who perceive themselves to be a burden upon others, from committing suicide." *Id.* at 608.

To confirm the right of the States to preserve and protect human life, and to prevent the abuses that would arise if assisted suicide were legalized, *amici* ask the Court to uphold the New York and Washington statutes banning assisted suicide.

CONCLUSION

For the foregoing reasons, *amici curiae* respectfully request this Honorable Court to reverse the judgments in Cases 95-1858 and 96-110.

Respectfully submitted,

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November 7, 1996

APPENDIX

APPENDIX

List of *Amici* from the New York General Assembly

Senator Kenneth P. La Valle (Rep.-Conserv.-Ind.-Property Tax Cut) Chairman, Higher Education Committee	1st District
Senator Ceasar Trunzo (Rep.) Chairman, Civil Service & Pensions Committee	3rd District
Senator Owen Johnson (Rep.) Vice-President *Pro Tem*	4th District
Senator Kemp Hannon (Rep.) Chairman, Health Committee	6th District
Senator Dean G. Skelos (Rep.)	9th District
Senator Frank Padavan (Rep.) Chairman, Cities Committee	11th District
Senator George Onorato (Dem.) Secretary, Senator Minority Conference Ranking Minority Member, Veterans Committee	14th District
Senator Serphin R. Maltese (Rep.) Chairman, Elections Committee	15th District
Senator Seymour P. Lachman (Dem.)	22nd District
Senator John J. Marchi (Rep.) Chairman, Corporations, Authorities & Commissions Committee	24th District
Senator Olga A. Mendez (Dem.) Chairwoman, Senate Minority Conference Ranking Minority Member, Social Services Committee	28th District
Senator Larry Seabrook (Dem.)	33rd District
Senator Joseph R. Holland (Rep.) Chairman, Social Services Committee	38th District
Senator William J. Larkin, Jr. (Rep.) Chairman, Racing and Wagering Committee	39th District
Senator Hugh T. Farley (Rep.) Senate Majority Whip Chairman, Banks Committee	44th District
Senator John A. De Francisco (Rep.) Chairman, Tourism, Recreation & Sports Development Committee	49th District
Senator Jess J. Present (Rep.) Deputy Majority Leader (Administration) Chairman, Commerce, Economic Development & Small Business Committee	56th District

Senator Dale M. Volker (Rep.) Chairman, Codes Committee	59th District
Assemblyman Robert C. Wertz (Rep.Conserv.)	6th District
Assemblyman Thomas F. Barraga (Rep.) Ranking Minority Member Education Committee	7th District
Assemblyman John J. Flanagan (Rep.-Conserv.)	9th District
Assemblyman James D. Conte (Rep.) Ranking Minority Member, Governmental Employees Committee	10th District
Assemblyman Philip B. Healey (Rep.) Assembly Deputy Minority Leader	12th District
Assemblyman William Scarborough (Dem.)	29th District
Assemblyman Denis J. Butler (Dem.) Assistant Speaker *Pro Tem*	36th District
Assemblywoman Catherine Nolan (Dem.) Chairwoman, Labor Committee	37th District
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Assemblyman Jules Polonetsky (Dem.)	46th District
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Assemblywoman Aurelia Greene (Dem.) Chairwoman, Banks Committee	77th District
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Assemblyman John J. McEneny (Dem.)	104th District
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Assemblyman David R. Townsend, Jr. (Rep.-Conserv.) Ranking Minority Member, Labor Committee	115th District

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Assemblyman Joseph T. Pillittere (Dem.) Chairman, Tourism, Arts & Sports Development Committee	138th District
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Assemblyman Richard J. Keane (Dem.)	145th District
Assemblyperson Sandra Lee Wirth (Rep.)	148th District

List of *Amici* from the Washington General Assembly

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Senator James E. West (Rep.)	6th District
Rep. Assistant Floor Leader	
Senator Alex Duccio (Rep.)	14th District
Rep. Deputy Floor Leader	
Senator Joseph P. Zarelli (Rep.)	18th District
Senator Daniel P. Swecker (Rep.)	20th District
Senator Jim Hargrove (Dem.)	24th District
Senator Bob Oke (Rep.)	26th District
Senator Pam Roach (Rep.)	31st District
Senator Gary Strannigan (Rep.)	38th District
Senator Emilio Cantu (Rep.)	41st District
Senator Jeanine Long (Rep.)	44th District
Representative Mike Sherstad (Rep.)	1st District
Representative Tom Campbell (Rep.)	2nd District
Representative Scott Smith (Rep.)	2nd District
Representative Duane Sommers (Rep.)	6th District
Representative Cathy McMorris (Rep.)	7th District
Representative Larry Sheahan (Rep.)	9th District
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Representative Mark G. Schoesler (Rep.)	9th District
Assistant Majority Floor Leader	
Representative Barney Beeksma (Rep.)	10th District
Representative Joyce Mulliken (Rep.)	13th District
Representative Jim Honeyford (Rep.)	15th District
Representative Steve Hargrove (Rep.)	23rd District
Representative Jim Buck (Rep.)	24th District
Representative Grant O. Pelesky (Rep.)	25th District
Representative Sarah M. Casada (Rep.)	25th District
Representative Lois McMahan (Rep.)	26th District
Assistant Majority Whip	
Representative Gigi Talcott (Rep.)	28th District
Majority Whip	
Representative Mike Carrell (Rep.)	28th District
Representative Tim Hickel (Rep.)	30th District
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Representative John Koster (Rep.)	39th District
Representative Val Stevens (Rep.)	39th District
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Representative Eugene Goldsmith (Rep.)	42nd District
Republican Caucus Vice Chair	
Representative Kathy Lambert (Rep.)	45th District
Representative Bill Backlund (Rep.)	45th District

Supreme Court, U.S.
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No. 95-1858
No. 96-110

IN THE

SUPREME COURT OF THE UNITED STATES

October Term,1996

DENNIS C. VACCO, Attorney General
of the State of New York,
GEORGE PATAKI, Governor of the State of New York
ROBERT M. MORENTHAU, District Attorney
of New York County

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D.,
and HOWARD A. GROSSMAN, M.D.

Respondents.

On Writ Of Certiorari To The U.S. Court Of Appeals For The Second Circuit

STATE OF WASHINGTON, AND CHRISTINE GREGOIRE
Attorney General of the State of Washington

Petitioners,

v.

HAROLD GLUCKSBERG, MD., ABIGAIL HALPERIN, M.D.,
THOMAS A. PRESTON, M.D. and PETER SHALIT, M.D., Ph.D.

Respondents

On Writ Of Certiorari To The U.S. Court Of Appeals For The Ninth Circuit

BRIEF AMICUS CURIAE OF THE INTERNATIONAL ANTI-EUTHANASIA TASK FORCE IN SUPPORT OF PETITIONERS

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39 pp

QUESTION PRESENTED

May a State protect its residents by prohibiting assisted suicide?

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
INTEREST OF AMICUS CURIAE	1
SUMMARY OF ARGUMENT	1
ARGUMENT	
I. IN STRIKING DOWN STATE LAWS PROHIBITING ASSISTED SUICIDE, THE SECOND AND NINTH CIRCUITS FAILED TO ADEQUATELY CONSIDER THE ECONOMIC PRESSURES THAT WOULD FORCE INDIVIDUALS TO ACCEPT ASSISTED SUICIDE	3
II. IN DETERMINING WHETHER STATES HAVE BOTH A VITAL AND RATIONAL INTEREST IN PROHIBITING ASSISTED SUICIDE, THIS COURT MUST CONSIDER THE IMPACT OF MANAGED CARE ON THE CONTEXT IN WHICH ASSISTED SUICIDE WOULD BE CARRIED OUT	5
A. Managed Care Has Changed the Very Basis upon which Health Care Is Provided	5
B. Managed Care Programs Use a System of Financial Incentives and Disincentives which Impose Conflicts of Interest between Patients and Their Doctors	7
C. Managed Care Programs Have Created Barriers between Physicians and Patients which Violate Patients' Rights to Receive Complete and Accurate Information about Their Health Care	10
D. To Preserve a Competitive Edge in the Marketplace, Managed Care Organizations Resist Attempts to Assure Patients' Rights	11

TABLE OF CONTENTS—*(Continued)*

	Page
E. Denial of Emergency Care which Often Occurs as a Result of Managed Care Can Create the Very Conditions that May Lead to Assisted Suicide	13
F. Managed Care Programs Often Operate in a Manner that Indicates a Quest for Only Short Term Effectiveness and Maximum Cost Containment	16
G. Patients' Fears of Dependence, Unremitting Pain and Loss of Dignity Are Often Exacerbated by the Practices of Managed Care Programs	18
H. The Appeals Process under Managed Care Is Often So Complex that Patients Could Consider Assisted Suicide to Be Their Only Recourse	22
I. The Policies of Managed Care Corporations Compromise the Quality and Expertise of the Medical Profession, Making It Imperative that States Have the Right to Protect Residents from Assisted Suicide	25
III. POLICIES WHICH PUT COST CONTAINMENT AND HEALTH CARE INDUSTRY PROFITS BEFORE PATIENT WELL-BEING MAKE IT ABUNDANTLY CLEAR THAT STATES HAVE BOTH A VITAL AND A RATIONAL INTEREST IN PROTECTING THEIR RESIDENTS BY PROHIBITING ASSISTED SUICIDE	26
CONCLUSION	28

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STATEMENT OF INTEREST

The International Anti-Euthanasia Task Force (IAETF) is the trade name of the Family Living Council, a non-profit corporation formed in 1976 to provide education in matters related to family life, health and related matters. The IAETF, with networkers throughout the world, addresses the medical-ethical issues of death and dying, health care delivery, the rights of the terminally ill, the chronically ill, the elderly, persons with disabilities and their families. Involvement of the IAETF in such matters includes education, advocacy, consultation, legislative analysis and networking. The IAETF is a major resource for individuals and groups seeking information about the rights of medically vulnerable individuals and their families.

This *amicus curiae* brief has been filed with consent of the parties. Letters of consent were filed with this brief with the Clerk of the Court.

SUMMARY OF THE ARGUMENT

The matter at bench is one of the most important constitutional challenges ever to face this Court. At stake is the determination of the very organizational purpose for which our society, under law, exists.

This Court will decide whether the state's foundational role as protector of the lives of all of its citizens is consistent with existing constitutional principle and the law, or whether this traditional state responsibility will be superseded and replaced by new and radical constitutional notions which prohibit states from protecting their citizens and, further, force states to countenance and facilitate the deliberate ending of human lives under the guise of compassion, elimination of suffering, and exercise of individual rights.

The current question before the Court is not whether dying patients have the right to end their suffering, as Respondents argue. (Certainly, the ending of suffering is a laudable goal and, if that were the real issue, there would be no controversy.) Rather, the issue before this Court is whether states

have the right to protect weak and vulnerable individuals as well as the greater societal good by prohibiting assisted suicide.

Strong emotional arguments are made by Respondents who seek to have this Court decide that existing state laws which proscribe assisted suicide are unconstitutional. Proponents of this radical theory of constitutional jurisprudence claim that the state has little or no legitimate interest in prohibiting assisted suicide because the assisted suicide of patients would permit them to determine "the time and manner of one's own death"[1] and would be used as " a treatment of last resort,"[2] to take place only after people have exhausted all treatment and comfort care possibilities.

As this brief will demonstrate, such conclusions and arguments are facile, designed as a veneer to deflect the Court's attention from the context in which legalized assisted suicide would be practiced. This brief argues that assisted suicide, as it would take place in the "real world," demonstrates both the rational and vital state interests promoted by state laws which currently outlaw assisted suicide.

The "last resort" claim is based upon the false premise that virtually every American citizen or resident has access to wanted medical treatment and necessary health care. Further, it mistakenly assumes that all necessary time and health care resources would be at the disposal of each suicidal patient prior to any implementation of physician facilitated death.

The reality of the United States health care delivery system belies these soothing assurances. An increasing number of people are experiencing great difficulty in obtaining necessary medical services, in part because of the ongoing transition from "fee for service" medicine to "managed care." In such a milieu, this brief argues, assisted suicide would be especially dangerous.

Managed care systems often have financial incentives which impose conflicts of interest between patients and their

1. *Compassion in Dying v. Washington*, 79 F.3d 790, 793 (9th Cir. 1996).

2. F. Miller, T. Quill, et al, *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119,120 ((1994).

own doctors. These conflicts create the potential for denial of wanted and needed medical care based on pecuniary, rather than medical, considerations. In turn, the suffering caused by denied or delayed care can create a desire for assisted suicide.

The "medical practice" of assisted suicide would not be implemented in a vacuum. There is nothing to indicate that a judicially created transformation of assisted suicide from a crime into a legitimate form of medical treatment would cause the health care delivery system to become more responsible to patient needs, nor would it afford a compassionate means for patients to have their suffering alleviated. If anything, the availability of assisted suicide would likely result in a decreased amount of time and attention given to treating and alleviating significant medical problems, such as pain, particularly when assisted suicide would be far less time-consuming and less costly than interventions which alleviate pain while not taking the patient's life. This latter point is especially pertinent in a health care system dominated by managed care.

It is within the context of the growing managed care system of health delivery and the growing prominence and influence of for-profit health maintenance organizations (HMOs) that the far reaching implications of striking laws which prohibit assisted suicide must be considered. Considering the financial implications of legalizing assisted suicide as it relates to proper patient care, a state not only has the right but the positive responsibility, to protect its citizens by prohibiting assisted suicide.

I. IN STRIKING DOWN STATE LAWS PROHIBITING ASSISTED SUICIDE, THE SECOND AND NINTH CIRCUITS FAILED TO ADEQUATELY CONSIDER THE ECONOMIC PRESSURES THAT WOULD FORCE INDIVIDUALS TO ACCEPT ASSISTED SUICIDE.

The Second Circuit Court in *Quill v. Vacco*[3] erroneously disregarded the importance of the significant economic and psychological pressure that would be placed on individuals if states were barred from prohibiting assisted suicide. In strik-

3. *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996).

ing down New York's laws against assisted suicide, the Second Circuit nonchalantly suggested that any such pressures could be alleviated by state formulated guidelines: "In any event, the state of New York may establish rules and procedures to assure that all choices are free of such pressures."[4] Not only did this suggestion totally ignore the carefully drafted report of the New York State Task Force on Life and the Law,[5] which clearly outlined and documented the peril in which citizens would be placed if assisted suicide were permitted, even under guidelines intended to be protected, it also failed to take note of the reality of the current state of the health care delivery system.

Likewise, the Ninth Circuit, in concluding that state laws against assisted suicide are unconstitutional, paid little attention to this reality.

After a cursory acknowledgment that economic factors and lack of adequate health care may well influence an individual's decision to die by assisted suicide, the Ninth Circuit fastidiously decided to "stand aside from that battle."[6] The Court implied that, if assisted suicide were not available to those who are already injured by the lack of access to adequate health care, they would be further harmed: "On the other hand we are certainly not obligated to pile injury upon injury. . . ."[7]

In fact, by removing the states' rights to protect vulnerable citizens from the considerable economic pressure to die and get out of the way, the Second and Ninth Circuits did pile injury upon injury. In concluding that states should not be able to prohibit assisted suicide, both courts sent a bold message that access to death-producing medical intervention is a constitutional right, but access to life saving or life enhancing medical intervention is not.

4. Id, at 730.

5. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994).

6. Supra note 1, at 826.

7. Id.

II. IN DETERMINING WHETHER STATES HAVE BOTH A VITAL AND RATIONAL INTEREST IN PROHIBITING ASSISTED SUICIDE, THIS COURT MUST CONSIDER THE IMPACT OF MANAGED CARE ON THE CONTEXT IN WHICH ASSISTED SUICIDE WOULD BE CARRIED OUT.

A. Managed Care Has Changed the Very Basis upon which Health Care Is Provided.

In an effort to control unnecessary medical costs and improve the efficiency of health care, a transition of monumental import is currently taking place in the health care system. This transition is from a traditional "fee-for-service" system to a "managed care" system of health care delivery.

Under the fee-for-service system, health providers were paid for each service performed. This sometimes led to patients' being overtreated and subjected to interventions that were futile. In the fee-for-service system, health providers had a financial incentive to exhaust all treatment possibilities or provide unnecessary care since the more treatment that was given, the greater was a provider's income.

Managed care operates in a manner that is almost a reverse of the fee-for-service system. Under managed care, health providers are encouraged by a myriad of incentives and disincentives to control costs by *limiting* treatment and care. Health care professionals now find that their incomes, in large part, depend upon providing fewer, not more, services.

While there is nothing inherently wrong with the concept of managed care, nor with the attempt to appropriately control health care costs, managed care, as it presently operates, has caused enormous problems: "Prodded by large companies fed up with rising medical costs, the new medicine's entrepreneurs have turned health care into a corporate battlefield increasingly governed by the promise of stock market wealth, incentives that reward minimal care and a brand of aggressive competition alien to front-line doctors. . . ."[8]

8. Larson, *The Soul of an HMO*, Time, Jan. 22, 1996, at 45.

The usual and traditional presumptions about health care financing and delivery have been turned inside out, and its effects are being felt by millions of people.

In 1995 up to 130 million people were in some type of managed care program.[9] Among American workers who are covered by health insurance, seventy-one percent are in managed care programs[10] and, according to the Health Care Financing Administration's Office of Managed Care, eighty thousand Medicare beneficiaries are being transferred each month from traditional fee-for-service health plans into managed care programs.[11]

The number of physicians affected by the growth of managed care is also increasing rapidly. Whereas physicians used to be self-employed and, thus, were ultimately in charge of how much time they spent with patients and how much care they wished to provide for a certain fee, more and more doctors are now becoming employees who are subject to control by managed care organizations. According to the American Medical Association, only slightly over half of doctors remained self-employed by 1995.

Indicative of the new way in which medicine is practiced is the terminology now used in conjunction with medical care. Provider-consumer business terminology has largely replaced references to what was formerly called the physician-patient relationship. Such business oriented designations have caused grave concern among physicians.[12]

The agreements used in that provider-consumer relationship have undergone such a significant transformation that the meanings of commonly used words and phrases may now mean something far different to the consumer than they do to

9. D. Blumenthal and S. Thier, *Managed Care and Medical Education*, 276 J.A.M.A. 725 (1996).

10. Myerson, *Executives Are Cradled while Medicaid Benefits Are Cut for Rank and File*, N.Y.Times, March 17, 1996, at 1, 13.

11. Johnsson, *Managed Care Fraud*, Am. Med. News, May 20, 1996, at 3, 26.

12. See, e.g., J. Olivero, *Why "Providers" Instead of Physicians?*, 156 Arch. Inter. Med. 2148 (1996).

the provider.[13] Additionally, this consumer-provider construct bears striking similarity to one which is contractual in nature. In a contractual relationship, however, there is generally some type of parity as it relates to information. That parity is lacking in the medical realm under managed care. It is the provider who has virtually all of the information. It is the provider who may withhold information on the basis of possible benefit or potential harm to the provider. It is the consumer who often does not have adequate information, because the provider has withheld it.

This presents a clear conflict for physicians and increases the possibility of grave harm to patients, a matter clearly relevant to the matters before the Court. If states were prohibited from banning assisted suicide, patients who were denied full access to information about the availability of treatment could be led to believe that assisted suicide was their only remaining option.

B. Managed Care Programs Use a System of Financial Incentives and Disincentives which Impose Conflicts of Interest between Patients and Their Doctors.

Under the doctrine of informed consent physicians have a common law duty to provide patients with all information that is material to that patient's treatment decisions. This duty encompasses informing patients about all reasonable treatment alternatives, and the risks and benefits of each, regardless of cost.[14]

Additionally, a patient has the right to be told about financial incentives that may exist to induce physicians to manipulate the range of options offered to the patient. The physician has an obligation to "disclose personal interests

13. See, e.g., R. Marker and W. Smith, *The Art of Verbal Engineering*, 35 Duq. L. Rev. 81 (1996).

14. *Cobbs v. Grant*, 8 Cal. 3d 229 (1972).

unrelated to the patient's health, whether research or economic, that may affect the physician's professional judgment."[15]

Despite the existence of clear requirements for such disclosure, managed care programs have created barriers between physicians and patients which threaten a patient's right to receive complete and accurate information and which compromise the professional responsibility of physicians. These barriers arise from a combination of factors: a method for health services payment referred to as "capitation," a combination of financial incentives and disincentives, and the existence of what are called "gag rules" in managed care contracts.

These approaches, used by managed care organizations, hold down costs by controlling physicians' fees and limiting patients' access to services. They could be accurately described as a "carrot and stick" method which compensates physicians in direct proportion to how little they do for patients.

Under the "capitation" approach, the managed care organization pays a flat fee per patient per month to a physician or group of physicians. For example, under one managed care plan, physicians receive $8.43 each month for every male patient between the ages of twenty-five and forty-four and $10.09 per month for each female patient between the ages of twenty and twenty-four.[16]

15. *Moore v. Regents of the University of California*, 793 P. 2d 479, 271 Cal. Repr. 146 (1990).

16. *Compromising Health Care*, Wash. Post, June 16, 1996, at C8. At the same time that doctors and other health professionals are being pushed to see more and more patients for less and less pay, and as patients are often being denied needed treatment, it is estimated that profits of twenty to thirty percent are going into the pockets of investors. In 1995, the total compensation package of the typical health care corporate CEO was close to $2.9 million. Auerbach, *As the Marketplace Changes, Consumers Are Caught in the Middle*, Wash. Post, June 25, 1996, at Z12. Several earned between $8.8 and $15.5 million per year. Freudenheim, *Health Chief's Big Paychecks for Chopping Costs*, N. Y. Times, Apr. 11, 1995. That does not take into account stock dividends paid to investors.

In return for the monthly fee per patient, the physician is to provide all medical services (subject to the terms of the managed care contract) for each covered patient. These services generally include primary care, specialty care, hospitalization, prescriptions, and a broad range of other health care services. If, during any given month, the actual cost of care for the covered patients is lower than that of the fees paid, the doctor retains the excess. If, however, the actual cost of care exceeds the fees, the health provider loses money. The possibility of losing money by providing care can be a powerful incentive to deny even needed care.[17]

Another cost control method, often coupled with capitation, depends upon what is referred to as a "withhold" in which the managed care organization withholds a percentage of the per patient fee that would ordinarily be paid to the physician. At the end of a certain period of time, the managed care program reviews the physician's practice and determines whether the physician should receive any of the withheld fees. If the managed care program determines that the physician is spending too much time per patient or that he or she is ordering too many diagnostic tests or providing too much treatment, the managed care organization retains the withheld fee. Amounts withheld in this manner vary from a low of eleven percent (withholds of less than eleven percent have been found ineffective as an incentive for physician's to limit services and referrals) to more than thirty percent.[18] Even when income is not withheld, some managed care organizations place a lien on future earnings or reduce the capitation fee as a means of penalizing a physician's failure to meet the fiscal expectations and requirements of the managed care program.[19]

According to data compiled in 1995 by the American Medical Association, one-third of doctors have capitated com-

17. See generally: Freudenheim, *Health Care in the Era of Capitalism*, N.Y.Times, Sept. 4, 1996, at 6E; and T. Bodenheimer and K. Grumback, *Capitation or Decapitation*, 276 J.A.M.A. 1025 (1996).

18. E. Morreim, *Balancing Act: The New Medical Ethics of Medicine's New Economics*, 35 (Georgetown University Press, 1995).

19. Id.

mercial contracts, and forty-eight percent are subject to some method of fee withhold. For doctors who have such contracts with manage care programs, nineteen percent of their income is attributed to capitation accounts.[20]

The wedge that such financial incentives and disincentives places between patients and doctors is intensified by another provision, referred to as a "gag rule," that is contained in many contracts between managed care organizations and physicians.

C. Managed Care Programs Have Created Barriers between Physicians and Patients which Violate Patients' Rights to Receive Complete and Accurate Information about Their Health Care.

Doctors who sign managed care contracts that have gag rules are prevented from providing often essential information to patients. Some gag clauses forbid a doctor from telling a patient about treatment options until the plan approves the specific treatment for that patient. Other programs prevent a doctor from telling a patient that a beneficial treatment that is not covered by the program is available elsewhere.

Under the gag clause provisions doctors say they cannot talk freely to patients about either their treatment options or about the particular managed care program's payment policies. They are even forbidden to tell patients that doctors who save money by withholding care get financial bonuses.[21]

Gag clauses also prohibit informing patients about outside "gatekeepers."

For example, one managed care organization sent a notice to physicians under contract with its program stating, "Do not discuss proposed treatment with [the managed care program's] members prior to receiving authorization" and further directed doctors to avoid discussing the procedures that must be followed to obtain such authorization[22]

20. Johnsson, *Trial Focus: Public Unease with Physician Incentives*, Am. Med. News, Aug. 12, 1996, at 1, 34.

21. Pear, *Doctors Say H.M.O.'s Limit What They Can Tell Patients*, N.Y. Times, Dec. 21, 1995, at A1.

In many managed care programs, it is the primary care physician who serves as the gatekeeper. Physician gatekeepers may come under considerable pressure to deny access to services as evidenced by a warning, given by one managed care organization to physician gatekeepers in its program, stating that the physicians' contracts would be terminated if they approved too many specialist referrals. [23]

Other programs rely on outside gatekeepers (who may be physicians, nurses or persons who are not trained in medicine). Outside gatekeepers may be located in a different city or state and have no personal contact with the patient or the patient's primary care physician. This type of gatekeeper or reviewer is often compensated on the basis of cost saving for the managed care organization.

The role of an outside reviewer was described by Dr. Linda Peeno when she testified before the House Commerce Health Subcommittee. Dr. Peeno, who had served as a medical reviewer for a managed care program, said she saved her employer money by denying treatment. She explained that, in one such case, her decision led to a man's death but, rather than being held accountable, she was financially rewarded. She earned an annual six-figure income by using her medical expertise to bring financial gains to the organization. "According to the managed care industry, it is not an ethical issue to sacrifice a human being for a 'savings,'" she said.[24]

D. To Preserve a Competitive Edge in the Marketplace, Managed Care Organizations Resist Attempts to Assure Patients' Rights.

Until very recently, health institutions, both public and private, were overwhelmingly non-profit endeavors. However,

22. Id.

23. Reuters Health News Service, *HMOs Respond to Member Complaints*, Aug. 20, 1996.

24. Gianelli, *Congress Considers Ban on Managed Care "Gag" Clauses*, Am. Med. News, June 19, 1995, at. 5, col. 1.

for-profit organizations are becoming the rule, rather than the exception, so that more than seventy percent of all HMOs are now for-profit corporations. With this change has come a shift in focus. Within the non-profit realm, any excess money is earmarked to improve services, access and care for the served population. In the for-profit sphere, money saved by limiting services benefits corporate shareholders. Meeting profit projections supplants meeting patient needs and is the driving force in the for-profit arena.

It would seem reasonable to assume that if patients demand types of care that may increase costs, managed care programs would respond since pleasing the customer has always been considered good business practice. The program could then pass on the costs to the consumer by raising premiums. However, this assumption misses a crucial point. In most cases, employers, not individual subscribers, pay the premiums, so they are the customers who must be pleased. Further, it is the employer, seeking to keep expenditures for employee benefits down, who will opt for a program that keeps rates down.

In 1995, a broad coalition of patient and provider groups drafted a set of standards on the rights of patients, including the right to information about provider incentives or restrictions that might influence practice patterns. Managed care organizations refused to sign on. Although the principles were endorsed by over one hundred groups including the American Medical Association, American Cancer Society, American Association of Retired Persons, and the Joint Commission on Accreditation of Health Care Organizations, a managed care representative explained that the principles seemed to be "too close to the operational issues" of managed care.[25] A subsequent attempt to adopt government regulations restricting managed care organizations' practice of incentives and gag rules was successfully resisted by managed care programs. The

25. Page, *Managed Care Firms Balk at Patient Rights Agreement*, Am. Med. News, Dec. 4, 1995, at 3, 23.

managed care industry claimed that such practices are important in "a fast-moving, intensely competitive industry."[26]

With their sites firmly on profit margins and beating the competition, it seems reasonable to predict that managed care corporations would be more than willing to reimburse for inexpensive assisted suicide services that would eliminate the need for some costlier services.

E. Denial of Emergency Care which Often Occurs as a Result of Managed Care Can Create the Very Conditions that May Lead to Assisted Suicide.

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires hospitals to provide "a standard medical screening evaluation"[27] to anyone who goes to an emergency room requesting care. In addition, the hospital must give any treatment that is necessary to stabilize the patient's condition, making use of all necessary and routinely available facilities of the hospital to reach a diagnosis that rules out the presence of a legally defined emergency medical condition.[28]

Emergency physicians are well aware that any delay in emergency care while seeking to obtain authorization for payment may be detrimental not only for the patient but may result in liability for the hospital.[29] However, managed care organizations and clinics run by health maintenance organizations are not within the scope of these requirements since "the plain wording of the statute makes reference only to 'hospitals' and shows legislative intent to provide emergency medical treatment by hospitals to all individuals."[30] Managed care organizations escape responsibility under EMTALA because they are only authorizing payment, not treatment.

26. Pear, *U.S. Shelves Plan to Limit Rewards to HMO Doctors*, N.Y.Times, July 8, 1996.

27. 42 USC 1395 dd (a).

28. 42 USC 1395 dd (b).

29. 42 USC 1395 dd (h). See, e.g., *Griffith v. Mount Carmel Hospital*, No. 92-1141-MLB, (D. Kan. Aug. 23, 1993).

30. *Dearmas v. Av-Med Inc.*, 814 F. Supp. 1103, 1108 (S.D. Fla. 1993).

Although, technically speaking, the managed care organizations cannot deny authorization to receive emergency treatment,[31] managed care policies do operate to block emergency room care by denying payment if pre-authorization is not obtained. Thus, a clear conflict exists between federally mandated medical screening examinations and the pre-authorization processes that are required by most managed care organizations. "Managed care requirements that patients be pre-authorized for emergency department visits or admissions are totally inconsistent with and unregulated by EMTALA."[32]

Emergencies are, by definition, unexpected and difficult to manage. Obtaining pre-authorization in an emergency situation can result in loss of time and loss of life. Nonetheless, managed care programs continue to require pre-authorization. As one members' handbook stated (in fine print), "Failure to contact the primary care physician prior to emergency treatment may result in denial of payment."[33]

According to Dr. Charlotte S. Yeh, chief of emergency medicine at the New England Medical Center in Boston, "In some ways, it's less frustrating for us to take care of homeless people than HMO members. At least we can do what we think is right for them, as opposed to trying to convince an HMO over the phone of what's the right thing to do."[34]

Such inconsistencies can place patients at risk and may force emergency room physicians to choose between providing necessary medical care or facing loss of hospital privileges for providing care that may not be reimbursed. In a survey of 1,047 board-certified emergency physicians, 18.6% said "they

31. "Managed healthcare plans cannot deny a hospital permission to examine or treat their enrollees. They may only state what they will and will not pay for, and regardless of whether a hospital is to be reimbursed for the treatment, it is obligated to provide the services specified in EMTALA." HCFA's Rules and Regulations, 59 *Fed. Reg.* 32,116 (1994).

32. S. Frew, *Managed Care, in Patient Transfers: How to Comply with the Law*, (American Academy of Emergency Physicians, Second Edition, 1995)

33. Pear, *HMO's Refusing Emergency Claims, Hospitals Assert*, N.Y.Times, July 9, 1995, at 1,12.

34. Id.

had been threatened or lost hospital privileges because they voiced concerns about quality of care."[35]

At a time when managed care cost containment provisions make even emergency care difficult to obtain, it would be incredibly naive to assume that the same managed care programs would authorize access to all medical options, some of which may be expensive, before approving the cost effective treatment of assisted suicide.

Indeed, managed care programs have consistently resisted providing services which, under fee-for-service, were previously included within even the most basic type of health care coverage. Even after there was tremendous public outcry about so-called "drive through deliveries" – in which new mothers and their infants were sent home from the hospital within hours of birth – many managed care programs maintained their refusal to pay for more than a day of hospitalization. It took federal legislation to require that new mothers and their infants could receive a minimum hospital stay of 48 hours after birth.[36]

It seems reasonable to believe that managed care programs which had to be forced to allow new mothers and infants to receive an additional 24 hours of hospitalization, may be less than willing to permit months of palliative care or great amounts of long term therapy for chronic conditions. This would be particularly true if the same managed care programs could authorize the provision of a lethal prescription as a quick and inexpensive means to "treat" the same condition.

In fact, most managed care organizations fail to provide services which address anything other than short term cost effectiveness.

35. *American Academy of Emergency Medicine Survey Preliminary Report*, Emergency Med. News, August 1995.

36. Veterans Administration.-HUD Appropriations Act of FY 1997, Pub. L. No.104-204, 110 Stat.2874, Title VI, Sec. 601 (Sept. 26,1996).

F. Managed Care Programs Often Operate in a Manner that Indicates a Quest for Only Short Term Effectiveness and Maximum Cost Containment

For medical conditions, like appendicitis or minor infections that can be addressed in the short term, managed care programs do relatively well. Problematic, however, is the care received by people who have conditions that require long term care. Thus, a relatively healthy person who enters into a managed care program will generally be satisfied with the program as long as his or her health remains good overall. If, as often happens, a person develops a condition, like multiple sclerosis, that requires on-going care, managed care often falls short of expectations.[37]

Additionally, while all managed care programs emphasize preventative care, not all have programs to prevent complications that can result from chronic disease. The way in which managed care deals with diabetes is an illustration of the quest for short term cost effectiveness. Fewer that one-half of HMOs have implemented programs to manage diabetes[38] even though more than 14 million Americans are known to have diabetes,[39] which can cause blindness, kidney failure, nerve damage and is the fourth leading cause of death in the United States.[40]

Regimens that could result in greatly reduced costs in terms of patients' lives and health care resources have sometimes been ignored in the interest of immediate monetary saving. When the National Institute of Health (NIH) supported a study on diabetes that showed that good control would reduce the complications of diabetes, managed care organizations indicated a marked lack of interest in the program. According to Dr. Judith Vaitukaitis, director of the National Center for

37. Rosenthal, *Patients Say N. Y. HMOs Don't Deal Well with Complex Illnesses*, N.Y.Times, July 15, 1996, at A19.

38. Reuters Health News Service, *HMO Enrollment Surpasses 59 Million in U.S.*, Oct. 23, 1996.

39. Blakeslee, *Program to Cut Risks of Diabetes Surprisingly Fails to Lure Patients*, N.Y.Times, Feb. 28, 1994, at A1,5.

40. *New Diabetes Treatment May Block Worst Effects*, San Francisco Chron., June 14, 1993, at A3.

Research Resources at NIH, this stance on the part of managed care programs was due to the fact that the managed care organizations did not want to spend the extra time and resources that good control would require. She explained that "the benefit of reduced complications is not seen for years ahead and they [managed care organizations] don't see the benefit in reduced costs because of the rapid turnover of their members."[41]

This emphasis on quick profits has also been described by Dr. George Lundberg, editor-in-chief of the *Journal of the American Medical Association*, who stated, "Getting managed care companies to think in terms of the long term is starry-eyed. Profit is to be made here. The managed care companies are not interested in the long term."[42]

It would seem logical for managed care organizations to promote long term preventative care since this would result in future savings. However, according to health care consultant Theodore J. Weinberg, individuals change health care programs about every three or four years.[43] The advantages of long term preventative measures may not show up for ten years or more and, by that time, a person may be in another managed care program. Consequently, competitive managed care programs are unlikely to invest in outcomes that would not pay off within a short period since the investment in a prevention program paid for by one managed care organization may result in better health (and thus lower expenditures) for enrollees in a competitor's program.

With this short sighted approach to health care, the long term consequence could be greater numbers of debilitated individuals who would create additional strain on the health delivery system. This, in turn, could spur greater incentives for managed care programs to promote assisted suicide as what one euthanasia advocate has called "a new age form of hospice care."[44]

41. C. Marwick, *Effect of Managed Care Felt in Every Medical Field*, 276 J.A.M.A. 768 (1996).

42. Id.

43. Id.

44. *Kevorkian Takes Stand in Own Defense*, N.Y. Times, Apr. 28, 1994,

G. Patients' Fears of Dependence, Unremitting Pain and Loss of Dignity Are Often Exacerbated by the Practices of Managed Care Programs.

A 1996 Gallup poll, conducted for the National Hospice Organization, regarding public attitudes about assisted suicide found that, among their greatest fears about death, people fear most the prospects of dependence, pain and loss of dignity.[45] In many ways, the current practices in managed care programs operate in a manner that turns these fears into reality.

It is often chronically ill patients, particularly those who are elderly or poor, who are hardest hit by the cost containment aspects of managed care. Within HMO plans, such patients fare poorly in comparison to similar patients in fee-for-service plans.[46] Their plight may become even more pronounced in the future since these patients "account for a disproportionate share of health care expenditures and are therefore prime targets of cost containment." [47]

It is well known that chronic conditions can often be controlled or, at least, their progression can be slowed down if appropriate and necessary care is provided. The lack of emphasis placed on chronic care by managed care organizations can actually lead to patients' becoming dependent sooner than they would have been if appropriate care had been provided. Thus, managed care's lack of attention to chronic conditions may serve to heighten dependence which a great number of people fear and could actually lead to a greater number of people considering assisted suicide.

NOTES *(Continued)*

at A8. Dr. Stanley Levy, an internal medicine physician who specializes in geriatrics, called the activities of Jack Kevorkian "new age hospice care" while testifying for the defense during Kevorkian's trial in the death of Thomas Hyde, who died of carbon monoxide poisoning on August 4, 1993.

45. National Hospice Organization, Press Release, Oct. 3, 1996, at 2.

46. J. Ware, M. Bayliss, W. Rogers, M. Kosinski, A. Tarlov, *Difference in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 J.A.M.A. 1039 (1996).

47. Id., at 1040.

The fear of unremitting pain which causes great anxiety for patients and which some have said could lead them to seek assisted suicide is heightened due to the inaccessibility of pain control for many people. It is the lack of access, not an absence of such interventions, that creates this tragic situation. Patients are often forced to endure pain because third party payers refuse to reimburse for its treatment. In effect, "by rationing pain management on a financial basis, patients are being forced to consider death as their only option."[48]

Navigating the murky waters of services not covered, services not approved and the complex methods of co-payments is particularly difficult for patients who are in pain. They have precious little energy to deal with a system that seems to block their access to necessary pain relief at every turn.

This denial of needed pain control is most pronounced within certain categories of patients. In 1994, the State of California's "Summit on Effective Pain Management"[49] found that third party payers often restrict payment for pain-related services.[50] It further found that pain is more likely to be undertreated if the patient is a member of a minority, female, elderly, or a child.[51]

Among these groups who are undertreated, the problem of pain relief is especially difficult for the elderly. Until recently, management of pain in elderly patients was largely ignored, although findings indicate that the prevalence of pain in the elderly is known to be twice that of younger people and can be as high as eighty-five percent in older people living in

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48. K. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain and Symptom Mgmt. 289, 292 (1991).

49. In March 1994, the State of California sponsored a "Summit on Effective Pain Management" at which more than 120 health care practitioners, professional and public educators, representatives of professional schools and associations, and health care consumers met to identify and recommend solutions to legal, professional, and educational barriers to effective pain management.

50. State of California, *Report on "Summit on Effective Pain Management: Removing Impediments to Appropriate Prescribing,"* 5 (1994).

51. Id.

long-term care settings,[52] even though individualized pain management plans for older people can be highly effective.[53] The problem in a managed care context is that individualized plans are time consuming.

Nurses, in particular, have been important in providing the personalized attention needed for effective pain management plans. The nurse's role has been particularly important since it has been the nurse who has previously been able to spend the time to communicate carefully with the elderly patient so that pain control needs can be accurately assessed. Now, however, in attempts to reduce costs in the realm of managed care, many hospitals and other health facilities are cutting back on their nursing staffs and patients are finding that not only doctors, but nurses, no longer have time for them.

According to Howard Berliner, professor of health policy at the New School for Social Research, "Hospitals are under pressure from managed care to reduce costs, and they are looking at nurses as their highest-cost line item."[54] In many cases, nurses are being replaced with unlicensed aids who have neither the training nor skill required to serve as effective patient advocates.

The failure to allocate the necessary time and resources to giving adequate pain management creates the untenable situation, so greatly and rightfully feared by many people. This could well lead a patient to believe erroneously that "nothing can be done" to alleviate suffering and, in turn, this could result in a patient's choosing assisted suicide as the only available means to escape pain.

Patient concerns about loss of dignity are also heightened by the cost containment policies and requirements of managed care programs. It is difficult for patients to feel valued and

52. B. Ferrell, *Pain Management in Elderly People*, 39 J. Am. Geriatr. Soc. 64 (1991).

53. T. Fulmer, L. Mion, M. Bottrell *et al., Pain Management Protocol: Inappropriate Pain Management Leaves Both the Elder and the Nurse Feeling Unfulfilled and Unhappy with the Care*, 17 Geriatr. Nurs. 222 (1996).

54. Rosenthal, *New York Hospitals Cut Costs by Laying Off Nurses*, N.Y.Times, Aug. 19, 1996.

cared for when physicians are compelled to treat them as though they were assembly line products being processed in an allotted number of minutes. This production line mentality was described by Dr. Leonard Laster, distinguished professor of medicine and health policy at the University of Massachusetts Medical Center in Worcester: "Business managers working in the interests of cost-cutting now tell doctors how much time to spend with a patient, and many allow only ten minutes for a returning patient and no more than twenty minutes for a new patient. How can anyone perform even a passable evaluation in twenty minutes on an elderly patient with a massive written clinical record. . . .?"[55]

Mandated time restrictions are not the only thing that can leave patients feeling demeaned and unimportant. Sometimes the greatest assaults on one's sense of self-worth emanate from small indignities. When one of the nation's largest managed care companies experienced losses in 1995, it instituted cost cutting measures which included the refusal to provide gowns for gynecological exam patients. Patients were told to disrobe and then, instead of being provided with a gown, they were given a small square of paper on which they were to sit while awaiting the examination.[56]

It stretches credulity to think that managed care programs — which fail to reimburse for adequate pain control, control exam times down to the minute, and deny a patient even a simple gown with which to cover herself — would allot large sums of money for comprehensive services so that assisted suicide would be used only as a last resort.

It could be assumed that, if patients are faced with demeaning and life threatening conditions such as have been described, they need only avail themselves of the appeal or complaint procedures that are in place in large corporations, including large health care corporations. However, the process of appealing a managed care program's decision is often time-consuming, costly and beyond the ability of many patients

55. Laster, *Managed Care Translates to "Let the Patient Beware,"* Am. Med. News, Feb. 19, 1996, at 18.

56. Auerbach, supra note 16.

who are already using every ounce of energy and every financial resource to exist on a daily basis. Meanwhile, as the quest for administrative remedies drags on, the patient's agony remains unrelieved.

H. The Appeals Process under Managed Care Is Often So Complex that Patients Could Consider Assisted Suicide to Be Their Only Recourse.

When essential treatment is denied, the appeals procedure under managed care is often so complex and time consuming that the accompanying delays can cause a patient grave harm. Additionally, personnel investigating the appeal may not have expertise in assessing the actual medical condition or its appropriate treatment. One such case involved a child with an extremely rare kidney tumor that is fatal if not treated but has a ninety-seven percent cure rate with prompt surgery. The child's primary care physician sought permission from the group plan to refer the child to an out-of-group specialist, since the group itself had no one with the needed expertise in treating the child's condition. The group's acting medical director, an ophthalmologist (eye specialist), refused to authorize the referral, saying that an in-group physician should perform the surgery. When the child's parents appealed, the appeal procedure was handled by a nurse who also denied the referral.

This left the family with two options: Have the surgery performed by a surgeon who was unqualified for it or personally bear the cost of an experienced medical team outside the group. Her parents opted for the latter, and the child's condition was cured. However, the managed care group not only refused to pay for the surgery but also denied any reimbursement for the accompanying hospital costs, even though these costs were identical to those that would have been incurred if an in-group physician had performed the surgery.

It took close to four years but, in October of 1996, the managed care program was fined by the California Department of Corporations for failing to provide the child "as well as all member patients with all medically necessary physician

services." It was also found that the managed care program had failed to demonstrate that its refusal to refer the child to a qualified surgeon was unhindered by fiscal and administrative considerations.[57]

Unfortunately, many people who are denied care, give up. They have neither the money to obtain care outside their managed care program nor the inclination to embark on court challenges. The outcome for such individuals could mean that a potentially fatal, yet curable, condition is allowed to progress. If assisted suicide is permitted, such individuals may well find that the same managed care organization that denied reimbursement for life-saving interventions will approve reimbursement for life-ending medication.

Obtaining necessary services through HMOs has been particularly difficult for Medicare patients. For many elderly patients, the process required for peer review of an HMO's decision to deny them care is too confusing, involves long time delays, and ultimately ends up being a useless endeavor. These facts prompted a class-action lawsuit on behalf of the millions of Medicare beneficiaries who are in HMOs.[58]

The administration and the HMO industry contended that federal Medicare law "does not require an impartial review procedure for Medicare beneficiaries enrolled in HMOs before a termination or denial of their HMO services."[59] However, U.S. District Court Judge Alfredo C. Marquez found otherwise. He stated that Medicare patients in HMOs are entitled to immediate hearings whenever they are denied medical services.[60] The need for immediacy is particularly important for Medicare patients since, "When Medicare services are denied, they are often foregone and, depending on the medical condition, final adjudication may come too late

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57. *Comm'r of Corp. v. Takecare Health Plan*, (Cal. Dept. of Corp., No. 933-0290, OAH No. N 9412060, Oct. 29, 1996).

58. Between 1987 and 1995, the number of Medicare beneficiaries covered in capitated programs almost tripled. D. Berwick, *Payment by Capitation and the Quality of Care*, 335 New Eng. J. Med. 1227 (1996).

59. Pear, *Medicare Patients in HMOs Win Case*, N.Y.Times, Oct. 31, 1996.

60. *Grijalva v. Shalala*, No. 93-711, slip op. (D. Ariz. Oct. 17, 1996).

to rectify the situation, especially if the deprivation contributed to or resulted in unnecessary pain and suffering or death."[61]

In a strongly worded opinion, Judge Marquez noted that, even though there were regulations and guidelines that should have protected Medicare beneficiaries, they were not being followed. Complex and confusing in-house review procedures amounted to little more than "a 'rubber stamp' of the initial denial,"[62] which has "grave consequences because an HMO denial may mean the enrollee will go without medically necessary service."[63] He further noted, "Given the length of time it takes for further appeal of the HMO denial, deprivations will certainly have significant impacts on quality of life and some may even be life threatening."[64]

According to Judge Marquez, an HMO often "hides the ball"[65] and frequently doesn't let Medicare patients know that they have a "right to present additional evidence to the HMO for reconsideration."[66] He concluded, as did the District of Columbia Circuit Court in *Gray Panthers v. Schweiker,*[67] "Current procedures allotted to the elderly Medicare claimant, probably disadvantaged by disability and poverty, resemble playing against a stacked deck. . . ."[68]

Yet, it is not only patients that are detrimentally affected by the manner in which managed care organizations are presently operating. The impact on the medical profession as a whole and, along with it, the increased risk to patients which may not be evident for several years must also be considered.

61. Id., at 19.
62. Id., at 23.
63. Id., at 23-24.
64. Id., at 24.
65. Id., at 22.
66. Id., at 23.
67. *Gray Panthers v. Schweiker*, 652 F.2d 146 (D.C. Cir. 1980).
68. Id., at 172.

I. The Policies of Managed Care Corporations Compromise the Quality and Expertise of the Medical Profession, Making It Imperative that States Have the Right to Protect Residents from Assisted Suicide.

Credentialing procedures for those in the health care field are not new. For years professional organizations have established standards for credentialing physicians and other licensed independent practitioners. Historically, hospital review committees and other professional organizations examined a physician's educational background and professional competency to determine his or her ability to render appropriate medical care. With the advent of managed care, however, a new type of credentialing, known as "economic credentialing," was instituted. This type of determination about physicians' suitability to practice medicine is unrelated to the quality of care they provide or to their professional competency. Rather it is based upon economic criteria. Thus, if a physician is deemed to spend too much time with patients or found to be ordering too many diagnostic tests (even though the time and tests may have been medically appropriate), the physician risks dismissal from a health plan or physician group.[69]

Ironically, at the same time that managed care organizations have placed great emphasis on credentialing as it relates to competency in reducing costs, they have often paid far less attention to credentialing that would insure patient safety. For example, one HMO solicited physicians by mail and encouraged them to become providers within the managed care organization. The screening process for the physicians was limited to verifying that the physicians were licensed, had hospital medical staff privileges and were able to prescribe narcotics. No personal interviews and no investigations about prior medical malpractice claims were conducted.[70]

Although an increasing number of physicians are alarmed by the harmful impact of managed care upon professional practice, this may not be enough to deter young physicians,

69. See, e.g., Cal. Med. MEDFAX, (So. Cal. Ed.) Jan. 8, 1996, at 2.
70. See, e.g., *Harrell v. Total Health Care, Inc.* 781 S.W. 2d 58 (Mo. 1989).

just entering medical practice, from embracing managed care. Due to the increased competition for health care dollars and the decline of the traditional fee-for-service practice, many physicians feel compelled to contract with managed care firms out of a sense of economic survival. Since large managed care firms offer employers a reduced rate for employee health coverage, and since these firms, in turn, contract with physicians, physicians who practice in fee-for-service are being left high and dry. Thus, a young physician who is entering into practice with the burden of heavy medical school debts may find that the economic security of a managed care contract — flawed though it may be — is the only economically viable option.

Indeed, with managed care beginning to dominate the entire health care delivery system, doctors may find themselves forced to choose between practicing managed medicine or not practicing medicine at all.

III. POLICIES WHICH PUT COST CONTAINMENT AND HEALTH CARE INDUSTRY PROFITS BEFORE PATIENT WELL-BEING MAKE IT ABUNDANTLY CLEAR THAT STATES HAVE BOTH A VITAL AND A RATIONAL INTEREST IN PROTECTING THEIR RESIDENTS BY PROHIBITING ASSISTED SUICIDE.

As providers in a managed care environment, many physicians will continue to be sincerely motivated by respect for patient well-being and autonomy, but the cost factor will always lurk in the shadows. As precarious as the situation resulting from managed care is at present, it would only become worse if physician-assisted suicide were to be considered a legitimate and legal medical option. If states are not permitted to protect their citizens from assisted suicide, the managed care provider would, in many cases, become the managed death provider. Dr. Daniel Sulmasy described the link between managed care and assisted suicide in concise terms when he stated that "the movement toward managed care as a preferred means to control health care cost and the

movement toward managed death as the preferred means to control terminal suffering are strong, active and current."[71]

To gauge the accuracy of Dr. Sulmasy's warning, one need only reflect on the vise-like pressure placed on doctors that has been described above and examine what has happened when voters in the state of Oregon approved Measure 16, the "Death with Dignity Act," which permits assisted suicide under certain conditions.[72] Less than five weeks after Measure 16's passage, Oregon's Medicaid director, Jean Thorne, said that assisted suicide would be covered under a part of the Oregon Health Plan called "comfort care."[73] Noteworthy was the fact that, as assisted suicide was being scheduled as a covered service, other existing services for poor Oregonians were being scrutinized for cuts.[74]

While some may question any direct relationship between the passage of Oregon's assisted suicide measure and attempts to cut health services, the cost effectiveness of hastened death is as undeniable as gravity. The earlier a patient dies, the less costly is his or her care. In any event, dead patients do not threaten managed care profits.

Likewise, there are varied opinions about any link between cost of care and euthanasia in the Netherlands where thousands of assisted suicide and euthanasia deaths occur annually, and more than one half of those deaths are not requested by the patients who died.[75] Of note is the cost of

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71. D. Sulmasy, *Managed Care and Managed Death*, 155 Arch. Int. Med. 133 (1995). Although Sulmasy refers to managed death for "terminal suffering," it is highly unlikely that assisted suicide would or could be limited to those whose conditions are diagnosed as "terminal." See e.g., E. Chevlen, *The Limits of Prognostication*, 35 Duq. L. Rev.337 (1996); and Marker, supra note 13, at 90-94.

72. The Oregon statute was enjoined by federal district court Judge Michael Hogan the day before it was to take effect. See *Lee v. State of Oregon*, 891 F.Supp.1429 (D. Or. 1995).

73. Postrel, *State Could Cover Assisted Suicide*, Statesman Journal (Salem, OR), Dec. 1, 1994, at A1.

74. Deitz, *Lawmakers May Trim Health Plan*, Statesman Journal (Salem, OR) Jan. 9, 1995.

75. Marker, supra note 13, at 85. Although the Dutch practice of physician induced death began with the intent of offering patients greater con-

performing euthanasia in the Netherlands which, Dutch euthanasia practitioner Dr. Pieter Admiraal has explained, can be performed for about five guilders whereas the cost of a single day of hospitalization is five hundred guilders.[76] Perhaps coincidentally, perhaps not, the Netherlands has the lowest per capita health expenditure in all of Europe.[77] According to Dr. Jeffrey Jackson of the Walter Reed Army Medical Center in Washington, this low per patient expenditure "reflects an ongoing effort to ensure that Dutch physicians are sensitive to cost and practice economically prudent medicine."[78]

CONCLUSION

Managed care has been referred to as a "work in progress"[79] which may eventually work very well if improvements are made. But those improvements could take years as legislatures and courts wrestle with the complex problems and conflicts of interest inherent in managed care programs. Meanwhile, the issues before this Court demand immediate resolution.

This Court faces the momentous task of determining whether the United States Constitution precludes states from enacting statutes prohibiting assisted suicide. Proponents of a constitutional right to have a doctor actively participate in assisted suicide argue that the issue before this Court is one of individual rights. But their assertions ignore the context within which that activity would be undertaken.

NOTES *(Continued)*

trol over their own deaths, the practice of euthanasia and assisted suicide has actually increased the power and control of doctors, not patients. See generally: H. Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure* (New York: W.W. Norton & Co.1997).

76. R. Marker, *Deadly Compassion* 146 (New York: Wm. Morrow & Co. 1993).

77. Reuters Health News Service, *Lessons on Healthcare Reform from the Dutch*, July 22, 1996

78. Id.

79. P. M. Ellwood, *Managed Care: A Work in Progress*, 276 J.A.M.A. 1083 (1996).

This Court must decide the issue based not only on abstract notions of individual liberty but on the reality of the environment within which personal and medical decisions would be made. Only then can it determine whether the state laws under consideration sufficiently support valid state purposes and thus, pass constitutional scrutiny.

This brief has demonstrated that the current health care environment is evolving into a system defined by cost-cutting imperatives and dominated by a form of health insurance known generically as managed care. Further, it has shown that the very purpose of managed care, which is to reduce the cost of providing medical care, is accomplished, in large part, through a system that rewards reduced levels of care.

In such a milieu, the kind of treatment that modern medicine is capable of providing (e.g. pain control, symptom management, and treatment of depression which is often essential to patient well-being and a desire to continue living) can be difficult to obtain. This problem would be exacerbated if the less costly and less time consuming "service" of assisted suicide were available mandatorily as a constitutional right. This could well create scenarios in which agonized and depressed patients would elect to have their deaths facilitated since their relievable suffering went unalleviated because of their health providers' financial imperatives. Moreover, forcing physicians to elect between providing patients with care, at the risk of having their own incomes reduced, and suggesting assisted suicide as a cost saving measure, would place doctors in an ethical and moral conundrum. The deleterious impact of that would be felt by the medical professionals, patients, and society as a whole.

This is the reality with which the Court must grapple.

In sum, legalizing physician-assisted suicide in a health care system in which financial incentives would favor denying care and hastening death would create a profound injustice.

Rather than serving the noble cause of individual liberty, it would make a mockery of freedom, since the "choice" to commit assisted suicide would, in many cases, have essentially been predetermined by managed care's financial imperatives.

Decisions to die would often be based, not on the inability of physicians to control pain and limit suffering but on pecuniary determinations.

That being so, state legislative decisions to prohibit assisted suicide are constitutional since they serve vital and rational state interests. Such laws ensure that managed health care does not devolve into a system of managed death. They protect and reinforce the traditional ethics of the health care profession. They strengthen the bond of trust essential to the patient-physician relationship by preventing doctors from being tempted to end patients' lives in order to promote their own financial ends. Perhaps most importantly, they reinforce the essential moral concept that human beings are not commodities, that lives cannot be measured in pecuniary terms, and that rich or poor, powerful or weak, no one should be sacrificed to benefit financial bottom lines.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, *et al.*, *Petitioners*,

v.

TIMOTHY E. QUILL, *et al.*, *Respondents*.

WASHINGTON, *et al.*, *Petitioners*,

v.

HAROLD GLUCKSBERG, *et al.*, *Respondents*.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF OF AMERICAN ASSOCIATION OF HOMES AND SERVICES FOR THE AGING, *ET AL.*,* AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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The American Association of Homes and Services for the Aging is joined on its brief *amici curiae* by the following state associations:

Alabama Association of Homes & Services for the Aging
Arizona Association of Homes & Services for the Aging
Association of Ohio Philanthropic Homes, Housing and Services for the Aging
Connecticut Association of Homes & Services for the Aging
Delaware Association of Homes & Services for the Aging
Iowa Association of Homes & Services for the Aging
Life Services Network of Illinois
Louisiana Association of Homes & Services for the Aging
Oklahoma Association of Homes & Services for the Aging
Oregon Alliance of Senior & Health Services
Rhode Island Association of Facilities & Services for the Aging
Tennessee Association of Homes & Services for the Aging
Wisconsin Association of Homes and Services for the Aging

TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES	ii
INTEREST OF AMICI	1
SUMMARY OF ARGUMENT	3
ARGUMENT	5
I. THERE IS NO FUNDAMENTAL RIGHT TO ASSISTED SUICIDE, AND THAT CONCLUSION SHOULD END THE INQUIRY	5
II. THE STATES' COMPELLING INTEREST IN PROTECTING HUMAN LIFE OUTWEIGHS ANY RIGHT TO ASSISTED SUICIDE	10
A. Protecting the Sanctity of All Human Life is the Most Compelling of All State Interests	11
B. States Cannot Practicably Limit Physician-Assisted Suicide Only to Mentally Competent Patients Making Voluntary Decisions	13
C. Physician-Assisted Suicide Will Undermine the Trust that the Elderly and Their Families Must Have in Institutions and Organizations Serving Them	18
III. STATES MAY RATIONALLY DISTINGUISH BETWEEN A DECISION TO DECLINE LIFE-SUSTAINING TREATMENT AND ONE TO COMMIT SUICIDE	22
CONCLUSION	25

TABLE OF AUTHORITIES

Cases	Page
Bowers v. Hardwick, 478 U.S. 186 (1986)	6, 7
Collins v. City of Harker Heights, 503 U.S. 115 (1992)	8
Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990)	5, 7, 8, 11, 12, 13, 23, 24
Employment Division v. Smith, 494 U.S. 872 (1990)	20
FCC v. Beach Communications, Inc., 508 U.S. 307 (1993)	22
Gregory v. Ashcroft, 501 U.S. 452 (1991)	3, 22
Mills v. Rogers, 457 U.S. 291 (1982)	7
Nordlinger v. Hahn, 505 U.S. 1 (1992)	22
People v. Kevorkian, 527 N.W.2d 714 (Mich. 1994)	11
Planned Parenthood v. Casey, 505 U.S. 833 (1992)	6, 8, 9, 10, 12, 17
Reno v. Flores, 507 U.S. 292 (1993)	6, 8
Roe v. Wade, 410 U.S. 113 (1973)	9, 12
San Antonio Sch. Dist. v. Rodriguez, 411 U.S. 1 (1972)	25
Snyder v. Massachusetts, 291 U.S. 97 (1934)	6
Swanner v. Anchorage Equal Rights Comm'n, 874 P.2d 274 (Alaska), *cert. denied*, 115 S. Ct. 460 (1994)	20
Youngberg v. Romeo, 457 U.S. 307 (1982)	7

Statutes and Regulations

42 U.S.C. § 1395i-3	19
42 U.S.C. § 1396r	19
Religious Freedom Restoration Act of 1993, 42 U.S.C. § 2000bb	20
42 C.F.R. § 483.25	19

Other Authorities

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Thomas J. Marzen, *"Out, Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799 (1994)	24
Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1 (1985)	7
New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994)	13, 14, 24

INTEREST OF AMICI

The American Association of Homes and Services for the Aging (AAHSA), and its related state associations are national and state nonprofit membership associations that together represent over 5,000 not-for-profit facilities and organizations providing housing, health care, and other services to more than 1,000,000 aging and disabled individuals. Seventy percent of AAHSA homes and organizations have religious sponsors, which include Catholic, Protestant, Jewish, and Muslim denominations. Others are sponsored by private foundations, fraternal organizations, government agencies, unions, and community groups.

Many of AAHSA's members are nursing homes. Both its nursing home members and most other members also provide community-based services such as home health care, hospice care for those in the last stages of terminal illness, and specialty care for those with Alzheimer's disease and other forms of dementia. Other members provide housing for low- or moderate-income seniors, often with supportive services (*e.g.*, periodic routine tasks) or more intensive home-based services. Approximately 700 AAHSA members are continuing care retirement communities, which provide "continuum of care" health care and housing on one site for the remainder of their residents' lives: residents maintain independence in their own homes for as long as possible by using home-based services, but they receive skilled nursing home care if needed.

This case is of extraordinary importance to all Americans. It will affect how millions of people view and treat the end of their lives. It may fundamentally alter the

relationship between patient and physician or other caregiver. And it may erode this nation's long-held convictions about the intrinsic value of all human life.

In particular, though, the Court's decision will directly and practically affect all of AAHSA's 5,000 members. AAHSA members' mission is to provide both quality care and a high quality of life for people at the end of their lives. Their residents and clients increasingly choose to die outside a hospital—in an AAHSA member nursing home, housing facility, community care retirement community, or in their private home while receiving AAHSA member services. Most of the individuals they serve are seniors; many are frail and in the last stages of their lives. These individuals are among society's most vulnerable populations. Because such patients will become terminally ill or die while in their care, AAHSA's facilities and service organizations are among the few structures in American society that deal with death, and must directly confront end-of-life issues, on a daily basis.

Based on a report by the AAHSA Commission on Ethics in Long Term Care, and by resolution of its Board of Directors, AAHSA has declared that "all persons are sacred regardless of their physical or mental condition" and that it is "opposed to a physician or other person assisting another in the taking of their own life." App. 1a. Like the American Medical Association, AAHSA distinguishes between physician-assisted suicide and both the withdrawal of life support and the prescription of pain therapy that has an expected but unintended consequence of shortening life; "intention is important," and society has long recognized that the right to be free of bodily contact and to let nature take its course includes a right to refuse medical treatment. *Id.*

AAHSA fears that a decision by this Court establishing an overarching right to physician-assisted suicide would profoundly harm the lives of its members' 1,000,000 residents and clients. Many AAHSA members would undoubtedly exercise their right of conscience and refuse to participate in assisted suicides. But that would not eliminate such a decision's harm. Striking down dozens of State laws against assisted suicide would create a risk, which no regulatory safeguards could eliminate, of decisions for death that are made while a person is clinically depressed, incompetent, or overly vulnerable to coercion by others and by societal expectations. And it would inexorably move homes and services for the aging away from a culture of life, caring, and trust towards a culture of death and distrust.

SUMMARY OF ARGUMENT

The opinions of the Ninth and Second Circuits mistook the exception for the rule. Only in exceptional circumstances may judges countermand the majority's will as expressed through a democracy. Only in exceptional cases may judges take it upon themselves to solve complex and controversial societal problems—in essence, political questions. Especially when the governing political body is a State and the court is federal, *see Gregory v. Ashcroft*, 501 U.S. 452, 457-59 (1991), the exception must be well grounded in the Constitution and in this Court's jurisprudence. No such exception applies here.

There is no fundamental right to receive assistance in committing suicide. Our Constitution and history not only fail to support such a notion; they flatly contradict it. Nor can any right be deemed nonfundamental but

nevertheless of enough constitutional significance to require a "balancing of interests" or any other form of heightened scrutiny. History and the Court's unbroken precedent contradict even this more limited holding. What is worse, such a holding only *appears* more limited; it would necessarily free courts to balance away any number of State interests in favor of any number of hitherto unrecognized rights. The Ninth and Second Circuit decisions do not merely create this slippery slope; they themselves proceed well down the slope.

Even if there were a right to assisted suicide (fundamental or otherwise), it would give way to compelling State interests. The first is the most compelling interest of all, that of protecting human life. This Court and others have already recognized that a State may assert an interest in protecting *all* human life, without devaluing a particular person's life based on his physical or mental condition. As a corollary, the State has a compelling interest in protecting the lives of individuals who do not make competent or truly voluntary decisions to commit suicide. Even physician-assisted suicide's strongest proponents acknowledge as much. But they fail to acknowledge the experience of AAHSA's members and other health care providers showing that competency and voluntariness are so fluid, complex, and subjective, and terminally-ill patients so vulnerable to pressure, that nothing short of a prohibition on assisted suicide will serve the State's interest. Finally, the State has a compelling interest in maintaining the relationship of trust between organizations that serve the aging and their clients, as well as between physicians and patients. Physician-assisted suicide would poison that relationship

and create fundamental conflict with AAHSA members' missions.

Once the due process question is answered, the equal protection analysis should follow *a fortiori*. Once the distinction between the generally accepted right to refuse life-sustaining treatment and the claimed right to assisted suicide is determined to be constitutionally significant under the Due Process Clause, it is unquestionably rational under the Equal Protection Clause. The distinction also has long been recognized by AAHSA members, physicians, ethicists, legal societies, courts, and democratic majorities. For the Second Circuit to declare all these thinkers' conclusions *irrational*, and for it to miss the glaring inconsistency between its due process and equal protection holdings, reveals the decision for what it is: a novel substantive due process holding in disguise.

ARGUMENT

I. THERE IS NO FUNDAMENTAL RIGHT TO ASSISTED SUICIDE, AND THAT CONCLUSION SHOULD END THE INQUIRY.

The primary issue in this case is whether the Federal Constitution confers any right to receive assistance in committing suicide notwithstanding the laws of the many States that still make such conduct illegal and have done so for a very long time. No such right exists, and this Court can create one only if it jettisons firmly-established and unquestioned precedent on identifying which interests receive any sort of heightened protection under the Due Process Clause. Neither *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261

(1990), nor *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), strayed from that precedent, and the Court should not do so now.

Even the Ninth Circuit labeled "not controversial" the Court's description in *Bowers v. Hardwick*, 478 U.S. 186 (1986), of what liberty interests are deemed fundamental. *Compassion* Pet. App. 31a n.16.[1] An interest "not readily identifiable in the Constitution's text" must be " 'implicit in the concept of ordered liberty,' " or, stated differently, " 'deeply rooted in this Nation's history and tradition.' " 478 U.S. at 191-92 (citations omitted). This formulation has a very long pedigree, *see, e.g.*, *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (referring to a "principle of justice so rooted in the traditions and conscience of our people as to be ranked as fundamental"), which continues to this day, *see, e.g.*, *Reno v. Flores*, 507 U.S. 292, 301-02 (1993).

Even the Ninth Circuit did not venture to say that a fundamental right to suicide can exist under this standard. Not only is such a right not "rooted in the traditions and conscience of our people," *Snyder*, 291 U.S. at 105, but as numerous academic articles, court decisions, and now briefs to this court detail, both suicide and assisting suicide were widely considered criminal offenses for centuries; states largely decriminalized suicide for reasons other than changed attitudes about its morality, and a large majority of states still make assisting a suicide a felony. *See especially* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 17-100 (1985).

[1] The Ninth Circuit opinions as appended to the Petition for Writ of Certiorari in *Washington v. Glucksberg* are cited as "*Compassion* Pet. App. __." The Second Circuit opinion as appended to the Petition for Writ of Certiorari in *Vacco v. Quill* is cited as "*Quill* Pet. App. __."

Instead, the Ninth Circuit created out of whole cloth a new substantive due process doctrine designed to subvert the purpose behind limiting the range of interests deemed fundamental. According to the court, the identification of a nonfundamental liberty interest unleashes a "balancing test" that still "requires the state to overcome a substantial hurdle in justifying any significant impairment." *Compassion* Pet. App. 33a. The only support the court enlisted for its test was *Cruzan* and the earlier cases recognizing an interest in refusing medical treatment. But those cases cannot honestly be read to treat that liberty interest as anything other than fundamental.[2]

Other decisions directly contradict the Ninth Circuit's imagined framework. Nearly every decision declining to find a fundamental liberty interest simply ends its analysis without performing any scrutiny of the statute. *See, e.g.*, *Bowers*, 478 U.S. at 196 (brushing aside respondent's "assert[ion] that there must be a rational basis for the law and that there is none in this case"). The most this Court has ever suggested is that, if a liberty interest

[2] *See Cruzan*, 497 U.S. at 269 (" 'No right is held more sacred, or is more carefully guarded, at common law . . . .' " (citation omitted)); *Youngberg v. Romeo*, 457 U.S. 307, 315-16 (1982) (resting on a " 'historic liberty interest' " and an interest "recognized as the core of the liberty protected by the Due Process Clause"); *Mills v. Rogers*, 457 U.S. 291, 301 (1982) ("[T]his interest of the individual is of such importance that it can be overcome only by 'an overwhelming State interest.' " (citation omitted)).

exists that is not fundamental, a law need only be "rationally connected to a government interest." *Reno*, 507 U.S. at 303.

This Court should not follow the Ninth Circuit's attempted lead in creating a balancing test for non-fundamental rights. The Court has limited the list of fundamental rights because "[t]he doctrine of judicial self-restraint requires [it] to exercise the utmost care whenever [it is] asked to break new ground in this field." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). Such a balancing test could be applied to an endless list of newly-found interests that could never be deemed fundamental. Courts could then use the test—as the Ninth Circuit did here—to elevate an interest to fundamental status in all but name and to run roughshod over legitimate State interests by denigrating their importance. *Compassion* Pet. App. 63a-114a. Accepting the balancing test would give courts license to sidestep the "guideposts for responsible decisionmaking in this uncharted area." *Collins*, 503 U.S. at 125.

Cruzan provides no more support for substantively inferring a right to suicide than it does for creating a new framework for inquiry. The right against physical invasion of bodily integrity, on which *Cruzan* squarely rested its recognition of an interest in refusing treatment, *see* 497 U.S. at 269, simply does not apply to a desire to kill one's self by ingesting death-inducing drugs.

Planned Parenthood v. Casey and its predecessors are also not helpful, let alone "prescriptive," *Compassion* Pet. App. 57a, in inferring a right to suicide. The Court has disclaimed the Due Process Clause as a basis for a woman's interest in terminating her pregnancy. The

three Justices announcing the Court's judgment in *Casey* upheld *Roe v. Wade*'s finding of a liberty interest based on a concern for *stare decisis* principles and the Court's legitimacy, "whatever degree of personal reluctance any of us may have" for doing so. *Casey*, 505 U.S. at 854-69; *see also id.* at 871. Four more Justices voted to overrule *Roe*. *See id.* at 944-66 (Rehnquist, C.J., concurring in part and dissenting in part). If the Court today would not on a clean slate find a new fundamental liberty interest in choosing to terminate a pregnancy, it would be quite peculiar to hold that the reproductive choice decisions compelled the Court to find an entirely different new fundamental liberty interest.

Even if used to discern a different liberty interest, the reproductive choice decisions provide little guidance here. The Court has recognized that "abortion is a unique act" and that with pregnancy "the liberty interest of the woman is at stake in a sense unique to the human condition and so unique to the law." *Casey*, 505 U.S. at 852. Abortion involves ending what the Court has necessarily deemed only "potential life," *id.* at 870, not the fully realized life of a person seeking suicide.

Both the Ninth and Second Circuits rested their decisions on *Casey*'s dicta describing prior privacy decisions as "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy," and "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.* at 851. But *Casey* used that passage to frame its explanation that abortion involves more than "beliefs about these matters"; it is

"conduct" that is "fraught with consequences for others." *Id.* at 851-52.[3]

The lower courts lifted the *Casey* passage out of context and used it as an engine that can mint a practically unlimited number of new fundamental constitutional rights that contradict long-held societal consensus. For "[i]f physician-assisted suicide is a protected 'intimate and personal choice,' why aren't polygamy, consensual duels, prostitution, and indeed, the use of illicit drugs?" *Compassion* Pet. App. 10c (O'Scannlain, J., dissenting from denial of rehearing en banc by the full court). Especially in light of the *Casey* opinion's true holdings, this passage cannot be read to overturn decades of constitutional jurisprudence intended to limit courts' temptation to substitute their judgment for that of democratic majorities. This Court should take the opportunity to foreclose such a use of *Casey* by lower courts in the future.

II. THE STATES' COMPELLING INTEREST IN PROTECTING HUMAN LIFE OUTWEIGHS ANY RIGHT TO ASSISTED SUICIDE.

Petitioners and other *amici* raise several compelling state interests that prohibitions on assisting suicides promote. AAHSA focuses on three: the interest in protecting the sanctity of all human life, the interest in preventing suicides that are not truly made voluntarily by mentally competent patients, and a corresponding interest in preserving the trust the disabled and aging place in long-term care institutions such as AAHSA's members. A prohibition on physician-assisted suicide is necessary to preserve all human life, to protect against less-than-voluntary deaths, and to ensure that long-term care facilities and services for the aging do not become centers of death and suspicion.

[3] The Court's list of individuals bearing those consequences, *see id.*, applies with full force to the act of committing assisted suicide.

A. Protecting the Sanctity of All Human Life is the Most Compelling of All State Interests.

The Due Process Clause itself lists life as the first interest worthy of its protection. Prohibitions on suicide reveal that society has long recognized that the State's interest in preserving life can outweigh the individual's desire to die. Nor does the quality of the individual's life eliminate the State's interest; prohibitions on suicide or assisting suicide have never made an exception for terminal illness. *See Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (citing several cases and other authorities). Apart from the Ninth Circuit, courts and other thinkers throughout time have recognized that "it would violate the concept of human dignity to measure the value of a person's life by that person's physical and mental condition." *People v. Kevorkian*, 527 N.W.2d 714, 727-28 n.41. (Mich. 1994). Thus the Court in *Cruzan* held that, even when a patient is in a persistent vegetative state, "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." 497 U.S. at 282.

Here, too, the State may assert an unqualified interest in preserving all human life, including that of terminally

ill patients. The Ninth Circuit's attempt to diminish that interest to near-nothing based on its cavalier judgment that the terminally ill patient's life is not worth protecting, *Compassion* Pet. App. 63a-101a, runs counter to *Cruzan* and to an unbroken consensus throughout history.

The Court's reproductive choice precedent firmly supports the State at this point in the analysis. A central principle of cases from *Roe* to *Casey* is that the State's " 'important and legitimate interest in potential life' " becomes paramount upon viability. *Id.* at 871 (quoting *Roe v. Wade*, 410 U.S. 113, 163 (1973)). Even a terminally ill patient is a viable human life. *Cf. Compassion* Pet. App. 146a (Beezer, J., dissenting) (distinguishing between a patient seeking assisted suicide and a patient on life support by categorizing them as essentially viable and nonviable). The same decisions also acknowledge the State's " 'important and legitimate interest in protecting the health of the pregnant woman,' " notwithstanding the burdens State restrictions place on that very same woman's liberty interest. *Casey*, 505 U.S. at 875-76 (quoting *Roe*, 410 U.S. at 162).

Nothing short of a prohibition on ending a life will further the State's interest in protecting that life. Thus the reproductive choice decisions allow the State to prohibit abortions of viable fetuses. *Casey*, 505 U.S. at 879 (quoting *Roe*, 410 U.S. at 164-65). As in those cases, the State's interest in protecting a viable human life outweighs a burden on any liberty interest a terminally ill person arguably has in assistance to suicide.

B. States Cannot Practicably Limit Physician-Assisted Suicide Only to Mentally Competent Patients Making Voluntary Decisions.

Cruzan held that Missouri's compelling interest in preserving even vegetative human life outweighed a patient's interest in refusing medical treatment because it helped prevent "an erroneous decision to withdraw life-sustaining treatment," which "is not susceptible of correction." 497 U.S. at 283. Here, as in *Cruzan*, a serious risk of irreversible error exists—a risk that a patient's decision to commit suicide will not be made while he is sufficiently competent or will not be truly voluntary.

The Ninth Circuit cavalierly brushed aside these risks by making the naked assumption "that sufficient protections can and will be developed" to "ensure that the possibility of error will be remote." *Compassion* Pet. App. 103a-104a. The individuals who comprised the New York State Task Force on Life and the Law, with far more relevant experience than federal judges, found such a faith in safeguards "naive and unsupportable." New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (May 1994). AAHSA members' actual experience with terminally ill residents is similar.

Paradoxically, the same terminal illnesses that place a person within the lower courts' newly-"protected" class often cause clinical depression, neurological dysfunction, and corresponding competency questions. And no question exists that these ailments affect a person's decision to live or die: "patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.* at 13 (footnote omitted). Indeed, 95 percent of

all suicides "have a diagnosable mental disorder at the time of death." *Id.* at 11.

The proper response to a mental ailment is to treat it, not surrender to it. Treatment for clinical depression in particular can produce a complete recovery. Many people who initially express a desire to take their lives later regain their mental balance and regain a sense that their lives are worth living. Even sufferers of Alzheimer's disease, who over the long term face irreversible mental decline, experience day-to-day ebbs and flows in their lucidity.

All agree that a decision to take one's life should not be made while incompetent or clinically depressed. But merely imposing competency requirements on assisted suicide decisions cannot prevent such errors. Both competency and depression exist along subtle continuums that are not susceptible to precise measurement. Individuals can suffer a range from mild depression to psychotic depression; indeed, the same individual may slide from one to the other, with a correlating shift in their competency. And competency is a multifactorial concept; persons can be disabled in some cognitive areas and not others.

Almost all residents of AAHSA members experience what is called "aging in place": they begin their stays competent but *gradually* slide toward incompetency. Many, if not most, reach the point at which they are deemed incompetent before passing away or leaving the facility. At any given time, a facility's staff can identify some residents that are still clearly competent and some that are clearly not, but the majority falls somewhere in the undefined middle.

Competency determinations are problematic in and of themselves. They depend on interview measurements that are highly subjective and highly variable across interviewers. Psychological examination is also particularly susceptible to a diagnosis that merely confirms the examiner's pre-interview expectations. If diagnoses are made by physicians without advanced psychiatric training, the examiner is even more likely to overlook some mental illnesses or other competency factors. A physician also may base a determination on very infrequent contact with the individual; residents receive their daily care from nurses, and physicians may see them as little as once per month.

The risk that this sea of complex subjectivity may obscure the decision to die of a mentally incompetent person—a person who might regain his mental equilibrium and later choose to live—is a compelling reason for a State to enforce a prophylactic rule.

Equally compelling is the terminally ill's extraordinary vulnerability to the overt suggestions of others, to psychological pressure, or to perceived societal expectations that they take their own lives. Here, too, no regulation can assure that such pressures have not caused a less-than-willing suicide.

Terminally ill individuals are often disconcerted, preoccupied, emotionally unsettled, and fully confronting their existence and their mortality for the first time. They are seeking aid and answers from those around them. They are, almost by definition, physically frail—often severely fatigued, in pain, and having trouble performing simple tasks such as breathing, eating, and relieving themselves. They may experience depression or

other mental deficits that do not raise serious competency questions but nonetheless further reduce the independence of their decisionmaking.

Such vulnerable individuals may face pressure to take their lives from several sources. One is the physician herself. The original three-judge panel was correct that "[p]hysician neutrality and patient autonomy, independent of their physician's advice, are largely myths. Most patients do what doctors recommend." *Compassion* Pet. App. 15d. Another source is the individual's family. A family's suggestion may be spurred by a selfish desire to lift the financial and emotional burden of caring for the terminally ill,[4] or merely by an honest belief, not otherwise shared by the individual, that a faster death is better for him.

A third source is society as a whole. Even in the absence of overt or subtle suggestion by medical personnel or family members that taking one's life is "the right thing to do"—even in the presence of statements reassuring the patient that the choice is his—he may feel an unwanted obligation to unburden his family and society of himself. Our choices, even our most important and personal ones, are constrained by accepted norms. We

[4] Terminally ill patients typically have very high medical costs. Medicare payments provide one indicator: In recent years, expenses for patients in the last year of their lives have accounted for between 27.2 percent and 30.6 percent of all such payments. *See* James D. Lubitz & Gerald F. Riley, *Trends in Medicare Payments in the Last Year of Life*, 328 New Eng. J. Med. 1092 (1993). Society may reasonably consider whether this is the best possible allocation of either public or private resources, but it should not reallocate them by pushing the elderly to kill themselves.

largely do what is expected of us, and the terminally ill may see taking their own lives as expected of them.

Indeed, the very act of constitutionalizing a right to suicide would alter attitudes about what society *expects* of individuals, not just what it *permits*. If this Court affirms the judgments below, physician assisted suicide will be more than an option; the nation's highest court will have declared it a constitutional right of enough weight to overcome the informed judgments of numerous democratic majorities and several admittedly compelling State interests. As one facility staff member has written in correspondence to AAHSA, residents

> may use such an assumption [that there is a Constitutional right to assisted suicide] as a further endorsement that the community also does not believe they have the right to continue to live.

The opinion for the Court in *Casey* relied explicitly on its recognition that the Court's earlier reproductive choice decisions have had such an effect. *See* 505 U.S. at 856 (noting that people have relied on *Roe* to "ma[k]e choices that define their views of themselves and their places in society" and "have ordered their thinking and living around that case"). This Court should not spur society to downgrade the value it places on human life and, by so doing, cause vulnerable, terminally-ill patients to "choose" suicide when they otherwise would not have done so.

One final barrier to true safeguards ensuring voluntariness springs from the intersection of the competency and coercion questions. Because competency determinations are highly subjective, a physician's belief that suicide is the better choice may either color her determi-

nation in favor of finding competency or, in the worst case, provide cover for her decision to act "paternally." Even if regulations require a second opinion, the reality of medical practice is that a physician's colleagues are unlikely to challenge her determination in close cases—especially if she has a hand in selecting the colleague. This level of subjectivity is simply not prone to effective regulation.

The same concerns that are present here—a vulnerable population and subjective, unpolicable questions of voluntariness and competency—have supported prophylactic rules against statutory rape, even though some minors can make competent, voluntary decisions to engage in sex with an adult. This Court should not dismiss such concerns in the context of physician-assisted suicide. Error here leads to an unquestionably wrongful taking of a human life, and lowering that risk is the most compelling of all State interests.

C. Physician-Assisted Suicide Will Undermine the Trust that the Elderly and Their Families Must Have in Institutions and Organizations Serving Them.

AAHSA's members and other providers of care and services to the aging are dedicated to the preservation and enhancement of each client's life and quality of life. This dedication is reflected in their respective charitable missions and in the care and compassion they show to all whom they serve, particularly the most vulnerable—the frail and infirm elderly who face end-of-life decisions. Congress also has not only acknowledged but mandated

this purpose for Medicare and Medicaid providers.[5] The statutes explicitly place the interest in residents' health and safety above some of their own wishes.[6]

The potential for physician assisted suicide would fundamentally alter the relationship between the aging and the organizations that serve them.[7] If prohibitions on assisted suicide are struck down, these institutions could be asked—and perhaps required—to be the agents of their clients' deaths rather than the protector and enricher of their lives. Such an obligation would conflict irreconcilably with the mission of many AAHSA members, both those that are religiously sponsored and those

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[5] *See, e.g.*, 42 U.S.C. §§ 1395i-3(b)(1)(A), 1396r(b)(1)(A) (requiring a facility to "care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident"); *id.* §§ 1395i-3(b)(2), 1396r(b)(2) (requiring a facility to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well being of each resident, in accordance with a written plan of care" for each resident).

[6] *See, e.g.*, *id.* §§ 1395i-3(c)(1)(v), 1396r(c)(1)(v) (residents have the right to "reasonable accommodation of individual needs and preferences, except when the health or safety of the individual . . . would be endangered").

[7] Assisted suicide creates an unquestioned conflict with specific norms and rules within facilities for the aging; the very act that may be deemed a constitutional right is otherwise specifically forbidden by regulation. *See, e.g.*, 42 C.F.R. 483.25(l) ("Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: (i) In excessive dose . . . (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued . . . .").

that are not.[8] AAHSA has received many letters from staff at member facilities expressing this view. As one wrote:

> If within our settings suicide is an abetted activity in response to the client's frustration, it can unwittingly become an encouraged activity in response to the agency's frustration. . . . I am unalterably opposed to undermining our few remaining pockets of caring culture by turning them into places of purposeful killing.

Many medical ethicists have written that introducing physician-assisted suicide into the physician-patient relationship will seriously undermine patients' trust that physicians are committed to preserving life, which is at the core of the relationship. *See, e.g.*, *Decisions Near the End of Life*, 267 J. Am. Med. Ass'n 2229, 2232 (1992); *cf.* American Medical Association *Code of Ethics* § 2.211 (concluding that physician-assisted suicide is "fundamentally incompatible with the physician's role as healer"). This breakdown of trust has even more drastic effects on the relationship between AAHSA members and the people they serve.

Unlike the selection of a doctor, the choice to enter a nursing home or other facility for the aging entails a fundamental life shift—uprooting one's home and placing large areas of one's life into the hands of others. Many seniors choose to make this move even when their physical state does not make it necessary because they view it as beneficial; they can trust in a facility's mission of preserving life and health when they entrust their lives to it.

One of this nation's most vulnerable populations relies on AAHSA members to show a compassionate commitment to life at one of its most trying yet precious moments. Especially if residents fear that the choice will be subtly forced upon them, physician-assisted suicide will threaten this relationship and poison the environment in which long-term care and services are provided, to the detriment of both caregiver and recipient. Some caregivers' refusal to participate in assisted suicide would not

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[8] Although the invalidation of statutes *prohibiting* assisted suicide would not *require* facilities to engage in such practices, states may move in that direction in response to this Court's decision. And although religiously-sponsored organizations have a constitutionally protected right to refrain from practices such as assisted suicide that violate their religious principles, the right does not extend to AAHSA members who are not religiously sponsored and who hold the same views on secular grounds.

Even for religiously-sponsored members, the right is not absolute. *Compare Employment Division v. Smith*, 494 U.S. 872 (1990) (finding no Free Exercise Clause violation of generally applicable governmental regulation of conduct) *with* Religious Freedom Restoration Act of 1993, 42 U.S.C. § 2000bb(b)(1) (requiring a compelling interest for regulations that burden religious exercise). If this Court finds a constitutional right to assisted suicide and a state attempts to require facilities to assist, advocates and perhaps courts will use the Court's finding here to argue that the State has a compelling interest in furthering the constitutional right. *Cf. Swanner v. Anchorage Equal Rights Comm'n*, 874 P.2d 274, 279-284 (Alaska) (finding that a compelling interest in preventing marital status discrimination outweighed the defendant's free exercise rights even though marital status has never received heightened constitutional protection), *cert. denied*, 115 S. Ct. 460, 460-62 (1994) (Thomas, J., dissenting from denial of certiorari) (noting the conflict among the courts on this issue).

If this Court finds some right to assisted suicide, it should at the least make clear that organizations serving the aging have a right of conscience to refuse to assist.

prevent the degradation of trust for the profession and aging community as a whole. One facility's staff member put it succinctly in a letter to AAHSA.

> Many of [the people we serve] believe if they enter a nursing home they will not receive compassionate and quality care. Why would we want to add another fear—the fear that we might take their lives?

There is no doubt that the State has a compelling interest in mitigating this fear.

III. STATES MAY RATIONALLY DISTINGUISH BETWEEN A DECISION TO DECLINE LIFE-SUSTAINING TREATMENT AND ONE TO COMMIT SUICIDE.

The Equal Protection Clause "simply keeps governmental decisionmakers from treating differently persons who are *in all relevant respects* alike." *Nordlinger v. Hahn*, 505 U.S. 1, 10 (1992) (emphasis added). This Court has stated many times, in many different ways, the extreme deference courts must pay to the State's determination of what is relevant for line-drawing purposes. A distinction is rational "if there is any reasonably conceivable state of facts that could provide a rational basis"; when there are " 'plausible reasons' " for the State action, " 'our inquiry is at an end.' " *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 313-16 (1993) (collecting cases; citation omitted); *accord Gregory v. Ashcroft*, 501 U.S. 452, 473 (1991).

In finding an Equal Protection Clause violation, the Second Circuit restated the bare-bones rational basis test but conspicuously omitted mention of the deference due

the State in determining what is rational. *Quill* Pet. App. 21a-23a. Even a cursory examination of the classification at issue confirms that, when such deference is given, prohibitions on physician-assisted suicide must be found constitutional.

The Second Circuit examined state laws that apply equally to all citizens, apart from one small group (people who require life-sustaining treatment). It then performed its own exquisite line-drawing to create a new small group with different, ill-defined, and in some cases unidentifiable characteristics ("mentally competent patients who seek to end their lives during the final stages of a terminal illness" through "prescribe[d] drugs to be self-administered"). *Quill* Pet. App. 4a. The two groups are not coextensive: not all patients who need life-sustaining treatment are terminally ill, *see, e.g.*, *Cruzan*, 497 U.S. at 266-67, and not all terminally ill patients need life-sustaining treatment. Incredibly, the Second Circuit concluded that the Equal Protection Clause *requires* the State to lift the court's newly-created group out of the general citizenry protected by laws against assisted suicide and place them in the small category currently occupied only by patients needing life-sustaining treatment.

Two rational bases exist for distinguishing between the two groups of patients. One is the age-old common law right to maintain one's bodily integrity, as explained so forcefully in *Cruzan*, *see* 497 U.S. at 269; that right comes into play only for patients needing medical treatment to survive. The other is the distinction between affirmatively employing medical science to shorten a patient's life and letting nature, in the form of some otherwise-fatal affliction, take its course. Although these

are thin lines, *see Cruzan*, 497 U.S. at 295-98 (Scalia, J., concurring), they are lines that have been drawn throughout much of history and are drawn today—by AAHSA,[9] by physicians (including groups submitting *amicus* briefs in this case),[10] by academic ethicists, by legal groups such as the American Bar Association,[11] by courts[12] (including this one),[13] by carefully selected interdisciplinary task forces,[14] and by democratic majorities that have criminalized one but not the other.[15]

For three or eight federal judges to declare this overwhelming weight of authority from many segments of society *irrational* is a breathtaking exercise of judicial hubris.

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[9] App. 1a-2a.

[10] *See, e.g.*, American Medical Association, Council on Ethical and Judicial Affairs, *Physician Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues L. & Med. 91, 92 (1994).

[11] American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues L. & Med. 117, 118 (1992).

[12] *See Compassion* Pet. App. 10c n.12 (citing court decisions). Judge Kleinfeld's analogy to General Eisenhower's decision to launch the Normandy invasion is a powerful dissection of the Ninth Circuit majority opinion's confusion on this issue. *Compassion* Pet. App. 163a (Kleinfeld, J., dissenting).

[13] While assuming a right to refuse treatment, *Cruzan* also noted the many laws criminalizing assisted suicide. *See* 497 U.S. at 279-80.

[14] *See* New York State Task Force, *supra*, at viii, 71.

[15] *See* Thomas J. Marzen, *"Out, Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 806 n.25 (1994) (citing statutes of forty states).

It is even more breathtaking when one realizes that the Second Circuit had already found the distinction to be *constitutionally mandated* under the Due Process Clause. One reaches the Equal Protection Clause issue at all only by first concluding, as the Second Circuit correctly did, that refusing life-sustaining treatment and ingesting poison are different enough to mandate a fundamental liberty interest in one but not the other. The Second Circuit's studied indifference to this glaring inconsistency, coupled with its peculiar balancing of State and liberty interests that would be appropriate only in a substantive due process analysis,[16] reveals a "creat[ion of] substantive constitutional rights in the name of guaranteeing equal protection of the laws," *San Antonio Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33 (1972).

CONCLUSION

The issue of physician-assisted suicide goes to the heart of our society's values. It is complex and stirs deep passions on both sides. States may choose to sanction the practice, and a few already have. But unless the Constitution says otherwise—and it does not—it is for the States to choose. "The Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all great questions would be decided by the judiciary"—yet the lower courts here have read *Casey* to do precisely that. *Compassion* Pet. App. 162a (Kleinfeld, J., dissenting).

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[16] *Quill* Pet. App. 31a ("What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence . . . ?" (citation omitted).)

This Court should return the federal judiciary to its proper role in our nation's government. The judgments of the courts below should be reversed.

Respectfully submitted,

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APPENDIX

A-1

AAHSA Statement on End of Life Decision Making

AAHSA holds that all persons are sacred regardless of their physical or mental condition. Society should ensure decency at every stage of life, but especially at the end of life. Public policy should make it possible for individuals and families to have support during the closing moments of life.

- We affirm that individuals, especially the vulnerable populations served by our members, should neither be enslaved to technology nor assumed to be obligated to use every means to preserve life. We are opposed to a physician or other person assisting another in the taking of their own life.
- We affirm that a person should be able to use medications to relieve pain and discomfort, even if an unintended consequence of such therapy would be that life may be shortened.
- We affirm that intention is important just as we affirm that there is a valid distinction between removing life support and the deliberate use of an instrument or drug to end life. In the former instance, the natural processes attending death are allowed to proceed; in the latter a person causes death by deliberate act.

AAHSA recognizes the diversity of the association membership and the universal desire of its members to provide the most compassionate and positive setting possible for the end of life. As deliberation on these ethical, religious and medical issues proceeds either in legislative

or judicial forums, the association strongly affirms that the members should be in the forefront of pastoral and palliative care.

- We believe that each AAHSA member is responsible for deciding whether and how to participate in societal decision that will determine how the dying process is treated in public policy, and
- We recommend that, at a minimum, each member develop and make explicit its values and perspectives on all end of life decisions so that the consumer, the resident, and the family can make an informed choice about the use of its services.

Approved by the AAHSA Board of Directors, Oct. 26, 1996

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF THE STATE OF NEW YORK, *et al.*,
Petitioners,

—v.—

TIMOTHY E. QUILL, M.D., *et al.*,
Respondents,

and

STATE OF WASHINGTON, *et al.*,
Petitioners,

—v.—

HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS
FOR THE SECOND AND NINTH CIRCUITS

BRIEF FOR THE INSTITUTE FOR PUBLIC AFFAIRS OF THE UNION OF ORTHODOX JEWISH CONGREGATIONS OF AMERICA ("UOJCA") AND THE RABBINICAL COUNCIL OF AMERICA, AS *AMICI CURIAE*, IN SUPPORT OF PETITIONERS

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23 pp

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTRODUCTION AND INTEREST OF *AMICI* 2

SUMMARY OF ARGUMENT 4

ARGUMENT 5

I. THE SUBSTANTIVE COMPONENT OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT DOES NOT CONTEMPLATE A FUNDAMENTAL LIBERTY TO PHYSICIAN ASSISTED SUICIDE. 5

II. THE PROHIBITION OF PHYSICIAN ASSISTED SUICIDE IS RATIONALLY RELATED TO LEGITIMATE STATE INTERESTS AND, THEREFORE, DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT. 13

CONCLUSION 19

TABLE OF AUTHORITIES

CASES

Board of Ed. of Kiryas Joel v. Grumet, 114 S. Ct. 2481 (1994) 2

Bowers v. Hardwick, 478 U.S. 186 (1986) 5, 6

City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985) 15

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) ..... *passim*

Compassion In Dying v. Washington, 49 F.3d 586 (9th Cir. 1995) 11, 17

Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) 11, 12, 16

Eisenstadt v. Baird, 405 U.S. 438 (1972) 5

Heller v. Doe By Doe, 113 S. Ct. 2637 (1993) . 15, 16, 18

Loving v. Virginia, 388 U.S. 1 (1967) 5

Moore v. City of East Cleveland, 431 U.S. 494 (1977) .. 5

Palko v. Connecticut, 302 U.S. 319 (1937) 5

Pierce v. Society of Sisters, 268 U.S. 510 (1925) 5

Planned Parenthood v. Casey, 505 U.S. 833 (1992) 10, 11

Prince v. Mass., 321 U.S. 158 (1944) 5

Quill v. Vacco, 80 F.3d 716 (2nd Cir. 1996) ..... *passim*

Roe v. Wade, 410 U.S. 113 (1973) 5

Skinner v. Oklahoma, 316 U.S. 535 (1942) 5

Twin City Bank v. Nebeker, 167 U.S. 196 (1897) 12

Williamson v. Lee Optical, 348 U.S. 483 (1955) 14

Zobrest v. Catalina Foothills Sch. District, 113 S. Ct. 2462 (1993) 2

STATE STATUTES

N.Y. Penal Law §§ 125.15, 120.30 14

N.Y. Pub. Health Law §§ 2960-79 14

N.Y. Pub. Health Law §§ 2980-94 14

Wash. Rev. Code § 9A.36.060 14

OTHER AUTHORITIES

J.D. Bleich, *Treatment of the Terminally Ill*, Tradition, A Journal of Orthodox Jewish Thought (30:3) 7

M. Chopko and M. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 576 (1995) 11, 17

F. Rosner, Modern Medicine and Jewish Ethics (1986) 7

F. Rosner, *Jewish Perspectives on Issues of Death and Dying*, 11 Journal of Halacha and Contemporary Society 50 (1988) 8

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INTRODUCTION AND INTEREST OF *AMICI*

This case raises the question whether individuals throughout the United States will be granted a right protected by the United States Constitution to seek and receive assistance in committing suicide. The courts below, on differing grounds, held that the states of New York and Washington could not proscribe assisting another person to commit suicide. *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996); *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996).

Amici believe that these appellate courts have misread precedents handed down by this Court in recent years and have invented a "right to die" not contemplated by any provision of our Constitution.

The Union of Orthodox Jewish Congregations of America (the "UOJCA") is a non-profit synagogue umbrella organization for over 1,000 Jewish congregations throughout the United States. It is the largest Orthodox Jewish umbrella organization in North America. Through its Institute for Public Affairs, the UOJCA researches and advocates the legal and public policy positions promoted by the Orthodox Jewish community. The UOJCA has joined in filing briefs with this Court in many of the important cases which affect the Jewish community and American society at large. *See, e.g., Bd. of Ed. of Kiryas Joel v. Grumet*, 114 S.Ct. 2481 (1994); *Zobrest v. Catalina Foothills Sch. Dist.*, 113 S.Ct. 2462 (1993).

The Rabbinical Council of America is the sister organization of the UOJCA serving as the largest rabbinical organization in the world with a membership in excess of 1,000 rabbis.

We are supporting the petitioners in this case because we believe that the invention of a

constitutionally protected "right to die" is at odds with the language, history, policies, and sound judicial understanding of the Fourteenth Amendment of our Constitution.

We have obtained the consent of the parties in each action to file this brief. We acknowledge that the opinions of the lower courts and the briefs of the parties to this case have raised many of the arguments which this Court must consider in rendering its decision herein. *Amici* offer this brief to the Court with the purpose of clarifying the position of the Orthodox Jewish community and, importantly, the position of traditional Jewish teaching with regard to this issue. We believe this is particularly important in this case because the lower courts (the Ninth Circuit in particular) have purported to discuss the approach of ancient and historical traditions to assisted suicide.

SUMMARY OF ARGUMENT

1. The Court should reverse the holding of the Court of Appeals for the Ninth Circuit. This Court has clearly established that those rights deemed to be "fundamental" and thus protected by the Due Process Clause of the Fourteenth Amendment are those which are either implicit in our concept of ordered liberty or deeply rooted in this nation's traditions and history. A right to physician assisted suicide is neither. As demonstrated by the Court of Appeals for the Second Circuit in its discussion of this issue, such a right is clearly not implicit in our concept of ordered liberty. As *amici* demonstrate in this brief, to the degree that our nation's traditions and history are derived from our Judeo-Christian heritage, it is clear that this right cannot be said to enjoy such a pedigree either. The Jewish tradition clearly prohibits the active assistance of suicide. Moreover, in inventing a new "right to die," the Ninth Circuit ignored this Court's clear admonitions against expanding the list of fundamental rights extrapolated from the Due Process Clause. The Ninth Circuit also misread this Court's holdings in *Planned Parenthood v. Casey* and *Cruzan v. Director, Missouri Dept. of Health* to elicit this new fundamental right. Neither of those cases, properly read, provide a basis for the Ninth Circuit's recognition of a constitutionally protected "right to die."

2. The Court should reverse the holding of the Court of Appeals for the Second Circuit. First, the State of New York has not (nor has the State of Washington) established a classification scheme which treats similarly situated terminally ill persons differently. In fact, New York has not created a classification scheme with regard to terminally ill persons altogether, for its ban on assisting suicide applies to the healthy and the ill equally. Second, even assuming that New York has created such a classification scheme, it is rationally related to a host of state interests – most notably, the state's interest in ensuring that the value of every human life is respected -- and thus is constitutional under the Equal Protection Clause of the Fourteenth Amendment.

ARGUMENT

I. THE SUBSTANTIVE COMPONENT OF THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT DOES NOT CONTEMPLATE A FUNDAMENTAL LIBERTY TO PHYSICIAN ASSISTED SUICIDE.

A. THE "RIGHT TO DIE" IS NEITHER IMPLICIT IN THE CONCEPT OF ORDERED LIBERTY, NOR DEEPLY ROOTED IN THIS NATIONS TRADITIONS AND HISTORY

The list of fundamental rights or liberty interests protected by the Fourteenth Amendment's Due Process Clause is short and well defined. Fundamental rights have been recognized in connection with child rearing, *Pierce v. Society of Sisters*, 268 U.S. 510 (1925), family relationships, *Prince v. Mass.*, 321 U.S. 158 (1944), procreation, *Skinner v. Oklahoma*, 316 U.S. 535 (1942), and the decision as to whether or not to beget or bear a child, *Loving v. Virginia*, 388 U.S. 1 (1967); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Roe v. Wade*, 410 U.S. 113 (1973).

Moreover, this Court has warned that it will offer "great resistance" to attempts to expand that list. *Bowers v. Hardwick*, 478 U.S. 186, 195 (1986). The Court in *Bowers* stated that "announcing rights not readily identifiable in the Constitution's text involves much more than the imposition of the Justices' own choice of values." *Id.*, at 191. Instead, this Court must proceed on the basis of criteria set forth in its earlier seminal decisions. It must find that the suggested right is "implicit in the concept of ordered liberty" such that "neither liberty nor justice would exist if it were sacrificed," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937), or that the suggested right is a liberty "deeply rooted in this nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977)(opinion of Powell, J.).

Accord., Bowers, 478 U.S. at 191-192.

In the context of these cases, even the Court of Appeals for the Second Circuit, which struck down New York's ban on physician assisted suicide on equal protection grounds, rejected the suggestion that such a fundamental right or liberty interest was to be newly created under the Due Process Clause. The *Quill* court held that this contended right "cannot be considered so implicit in our understanding of ordered liberty" and succinctly concluded that the "right to assisted suicide finds no cognizable basis in the Constitution's language or design," 80 F.3d at 724.

The Second Circuit also recognized that this suggested right is not deeply rooted in this nation's traditions and history. The court noted the prohibition of assisted suicide under the Common Law of England. *Amici* here offer for the Court's consideration the position of the Jewish legal tradition in its role as one of the central roots of this nation's legal structure.

It is well recognized that many of the laws of this nation are rooted in moral traditions brought to this country by her first settlers. Those moral traditions are derived from a familiar set of moral strands woven together in what has come to be referred to as our common Judeo-Christian heritage. It is well recognized that "if all laws representing essentially moral choices are to be invalidated under the Due Process Clause, the courts will be very busy indeed." *Bowers v. Hardwick*, 478 U.S. 186, 196 (1986). *Amici* are in no way suggesting that these cases ought to be decided by this Court on the basis of religious teaching. We are contending, however, that the Judeo-Christian rejection of physician assisted suicide informs us that it is not a fundamental right to be accorded constitutional protection.

The approach to treatment of the terminally ill in traditional Jewish sources is one which venerates the infinite value of human life. Judaism not only recognizes the inestimable value

of each life, but of every moment of that life as well. Thus, one may violate the sabbath to free an individual from a collapsed building even if it is clear that the person will only survive a short time. Code of Jewish Law (I:329:4), *cited in* J.D. Bleich, *Treatment of the Terminally Ill*, Tradition, A Journal of Orthodox Jewish Thought (30:3) at 52 (hereinafter, Bleich).

Under traditional Jewish law, the preservation of life outweighs virtually every other religious commandment.[1] Thus, for example, one should violate the sabbath or eat non-kosher foods in order to save a life. Although Jewish tradition does not champion asceticism or suffering, it does recognize that "life with suffering is, in many cases, preferable to cessation of life and with it the elimination of suffering." Bleich, at 52. Thus, the rabbinic commentary to Genesis (9:5)[2] notes that the Bible seemingly repetitiously prohibits fratricide after having already condemned homicide because of a recognition that in certain circumstances the taking of a life might be wrongly perceived as motivated by love or compassion; it is precisely in those cases, the Bible instructs us, that such an act still constitutes murder. *See* Bleich, at 53. While Judaism recognizes personal autonomy and freedom as religious values, it has also long recognized that they are values which are not paramount to all others.

The traditional Jewish position goes so far as to say that one ought not take any action that might actively hasten

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[1] One must sacrifice his own life in the face of violating any of the three cardinal sins: murder, idolatry or adultery. Even in those circumstances, however, under Jewish law the individual is to permit himself to be killed by his adversary, not sacrifice his own life. Thus, the Ninth Circuit's reliance upon the events at Masada, 79 F.3d at 807 fn.24, is misplaced for there the Jews may not have followed the principles of Jewish law by killing themselves. *See*, F. Rosner, Modern Medicine and Jewish Ethics (1986), at 252 *et. seq.*

[2] "But your blood of your lives I will require; from the hand of every beast will I require it; and from the hand of man, from the hand of a person's brother, will I require the life of man."

the death of the terminally ill person. *See* Talmud, Tractate Shabbat, 151b.[3] Nevertheless, it does carve out an extremely narrow exception for an individual who is deemed to be in the "throes of death." A person in such a state is essentially defined as one who is irreversibly certain to die within seventy-two hours. Bleich, at 64, fn. 24. In such limited circumstances, Jewish law permits those treating the patient to withdraw treatment so that death may occur naturally.[4] While there is great debate in Jewish legal sources over the application of these principles it is clear that nothing may be done to actively speed the death process. *See* F. Rosner, *Jewish Perspectives on Issues of Death and Dying*, 11 Journal of Halacha and Contemporary Society, 50 (1986).

Despite these clear principles – the mandate of *Bowers* and the clarity that this "right" is neither implicit in our understanding of ordered liberty nor rooted in our nation's traditions -- the Court of Appeals for the Ninth Circuit felt compelled to invent a new fundamental liberty interest, the right to die, under the Due Process Clause by a patchwork reading of this Court's precedents. The holding of the Ninth Circuit must be rejected for several reasons.

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[3] One must not move the patient in a way that might hasten death, "the matter is like a flickering flame; as soon as one touches it, the light is extinguished."

[4] Thus, Jewish law recognizes the dichotomy between the active assistance of suicide and the passive withholding of treatment such that death results.

B. THIS COURT'S PRECEDENTS CLEARLY WARN AGAINST EXPANDING THE LIST OF ALREADY ESTABLISHED FUNDAMENTAL RIGHTS

This Court has warned lower courts not to discover new rights implicit in the Due Process Clause. In *Bowers* it clearly stated:

> Nor are we inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause. The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority. The claimed right pressed on us today falls far short of overcoming this resistance.

Bowers, at 194-195. The Second Circuit followed this mandate while the Ninth Circuit ignored it. In its forty-eight page opinion, the Ninth Circuit devotes little more than two footnotes to *Bowers* and baldly asserts that the precedent neither controls nor is inconsistent with its conclusion. *Compassion In Dying*, 79 F.3d at 813 fn.65. Such disregard for the clear admonition of this Court is

troubling and telling; it (along with an inexplicable reliance on polling data to determine current societal attitudes toward suicide, *Id.*, at 810) suggests that the Ninth Circuit panel was sitting as a superlegislature, rather than as a court organized under our constitutional structure.

Respondents and their *amici* are, at bottom, pressing this Court to ignore its precedents which counsel resistance to expanding the category of fundamental rights. On this basis alone, the Court should rule in favor of petitioners.

In looking to justify the creation of this new liberty interest, the Ninth Circuit relied upon this Court's decision in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) which, after reviewing its previous decisions to grant constitutional protection for the fundamental rights of marriage, procreation, contraception, family relationships, child rearing, and education, stated, at 851:

> These matters involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, or meaning, of the universe, and of the mystery of human life.

The Ninth Circuit agreed with the district court that these sentences were "highly instructive" and "almost prescriptive" for creating a liberty interest in a person's choice to commit suicide. 79 F.3d at 813 (citations omitted).

It must be recognized that a majority of the justices in *Casey* indicated their belief that the underlying case of *Roe v. Wade* was either incorrectly decided or had sufficient doubts regarding its correctness to refrain from reaffirming it on its original (fundamental liberty) grounds. Rather, *Casey*'s majority was formed out of a need to respect the principles of *stare decisis*,

not the ringing reaffirmation of the fundamental right of more than twenty-years earlier. *See Casey*, 505 U.S. at 854. This makes *Casey* a most tenuous foundation for minting a new fundamental constitutional right. *See* Chopko, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 576 (1995).

As stated above, this Court has consistently resisted finding constitutionally protected liberty interests and has only done so after a careful and thorough analysis of the right in question. That being the case, it is inconceivable that a few passages found in *Casey* were intended by this Court as a springboard for courts to employ in the creation of new fundamental rights. That the Ninth Circuit believes so demonstrates how far it has strayed from this Court's precedents.[5]

The Ninth Circuit also based its holding upon *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), in which this Court held that "a competent person has a protected liberty interest in refusing unwanted medical treatments" even where such a refusal will inevitably result in death. *Id.*, at 278. From that narrow statement, the Ninth Circuit conjured a broad right to "hastening one's own death." 79 F.3d at 816. Once again, the Ninth Circuit's reasoning is flawed. The liberty interest discussed in *Cruzan* was necessarily limited to the refusal of unwanted medical treatment. This is apparent form the Court's derivation of this liberty interest from the well established tort law doctrine of informed consent. By virtue of an individual's right to determine who may treat his own body, the Court derived a

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[5] Ironically, the Ninth Circuit's first opinion in this litigation, *Compassion In Dying v. Washington*, 49 F.3d 586, 590 (9th Cir. 1995), accurately characterized such an attempt to base the creation of a new fundamental right to die on these abstract passages. The court stated: "To take three sentences out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to find these sentences 'almost prescriptive' in ruling on a statute proscribing the promotion of suicide is to ... ignore the differences between regulation of reproduction and the prevention of the promotion of killing a patient at his or her request.

corollary right to refuse the treatment of that same body. *Id.*, at 269-270. It is a much greater leap, however, to then conclude that one may seek assistance in afflicting his own body.

Moreover, the *Cruzan* Court emphasized the narrowness of its holding:

> This is the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a "right to die." We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897), where we said that in deciding "a question of such magnitude and importance...it is the [better] part of wisdom not to attempt by any general statement to cover every possible phase of the subject.

497 U.S. at 277. Consequently, *Cruzan* ought to be read as limited solely to its factual context – the right to refuse unwanted medical treatment – and not to create a broader right to hasten one's own death.

II. THE PROHIBITION OF PHYSICIAN ASSISTED SUICIDE IS RATIONALLY RELATED TO LEGITIMATE STATE INTERESTS AND, THEREFORE, DOES NOT VIOLATE THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT.

Having demonstrated that there is no fundamental right to physician assisted suicide contained in the Fourteenth Amendment, we proceed to the review of this state legislation under the Equal Protection Clause of the Fourteenth Amendment. It was upon this basis that the Court of Appeals for the Second Circuit struck down New York's proscription of assisted suicide. The Second Circuit held that New York lacked a rational basis for treating differently, what it deemed to be, similarly situated classes of terminally ill persons.

A. THE STATES HAVE NOT LEGISLATED THE DISPARATE TREATMENT OF SIMILARLY SITUATED INDIVIDUALS

Prior to proceeding to a discussion of rational-basis review, however, a threshold issue must be raised. Central to any equal protection analysis, including that engaged in by the Second Circuit, is the treatment by the state of similarly situated individuals (or classes of individuals) differently. To embark upon its equal protection analysis, the Second Circuit interpolated the creation of two categories of terminally ill persons into the New York statutory scheme. Thus, after reviewing the principles of rational-basis review, the court asserted that:

> New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering

prescribed drugs.

80 F.3d at 729. What is overlooked by this reasoning, however, is that the statute prohibiting the assisting of suicide does not speak to the terminally ill alone. It is a provision of the Penal Law that is generally applicable to those who would assist in the suicide of a perfectly healthy individual just as much as one who is terminally ill.[6] *See*, N.Y. Penal Law 125.15, 120.30. Thus, it is inappropriate to read as one whole cloth of this generally applicable provision and the legislature's decision to permit the refusal of continued life-support, N.Y. Pub. Health Law 2980-94, or resuscitation, N.Y. Pub. Health Law 2960-79.[7]

It has long been recognized that legislatures may seek to address various issues which confront our society piecemeal and need not address all phases of an issue at once and still have its enactments survive equal protection review. *See Williamson v. Lee Optical*, 348 U.S. 483 (1955). Here, the State of New York determined years ago that giving assistance to suicide was to be prohibited. *See Quill*, 80 F.3d at 733 (opinion of Calabresi, J., concurring). The fact that in more recent years the legislature has determined to permit a narrow class of individuals – the terminally ill on life-support – to arrange for the discontinuation of the active sustaining of their lives or for ordering that medical professionals do not intervene and resuscitate them should the life support mechanisms fail, does not indicate that the legislature has created a classification scheme among the terminally ill or as between the terminally ill and all

[6] Indeed, one of the most troubling aspects of this case is that those who advocate for a constitutionally protected "right to die" do not convincingly address how this right will be restricted to those who are terminally ill and wish to "die with dignity" as opposed to others who may for whatever reason decide that they no longer wish to live. We address this point further below.

[7] It is similarly the case that Washington's statute struck down by the Ninth Circuit is a statute of general applicability contained in its penal code section. *See*, Wash Rev.Code 9A.36.060.

other citizens.

Thus, the Second Circuit erred in holding that the New York statute violated the Equal Protection Clause for irrationally classifying groups of terminally ill persons differently. In fact, New York's laws do not classify the terminally ill into different categories. Therefore, rational-basis review is inapplicable.

B. THE STATUTES AT ISSUE ARE RATIONALLY RELATED TO LEGITIMATE STATE INTERESTS

Even assuming that these statutes are to be read together to create a statutory classification scheme that treats similarly situated persons differently, such schemes still fulfill the requirements of the Equal Protection Clause as enunciated by this Court and are constitutional.

As noted by the *Quill* court below, "[t]he general rule... is that state legislation carries a presumption of validity if the statutory classification is 'rationally related to a legitimate state interest.' *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985)." 80 F.3d at 725. Left unmentioned by the *Quill* panel was this Court's restatement of the principles underlying rational-basis review as succinctly summarized in *Heller v. Doe By Doe*, 113 S.Ct. 2637, 2642 (1993). There, this Court reaffirmed the fact that:

> rational-basis review in equal protection analysis is not a license for courts to judge the wisdom, fairness, or logic of legislative choices...[n]or does it authorize the judiciary to sit as a superlegislature to judge the wisdom or desirability of legislative policy determinations made in areas that neither affect fundamental rights nor proceed along suspect lines. For these reasons, a classification neither involving fundamental rights nor proceeding along suspect

> lines is accorded a strong presumption of validity. Such a classification cannot run afoul of the Equal Protection Clause if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose. Further, a legislature that creates these categories need not actually articulate at any time the purpose or rationale supporting its classification. Instead, *a classification must be upheld against equal protection challenge if there is any reasonably conceivable state of facts that could provide a rational basis for the classification...moreover...the burden is on the one attacking the legislative arrangement to negate* [sic] *every conceivable basis which might support it.*

Id. at 2642-2643 (internal quotes and citations omitted, emphasis supplied).

A host of rational legislative policy determinations underlie the decisions by these states to prohibit physician assisted suicide. In fact, many of these state interests and policy decisions are outlined, albeit rejected, by the majority opinion for the Ninth Circuit, 70 F.3d 816-831, and by the dissent filed in that case. *Id.* at 851-855. Those state interests include: (1) a state's interest in preserving life as recognized by this Court in *Cruzan*, 497 U.S. at 282; (2) a state's interest in preventing suicide; (3) a state's interest in assuring that third parties do not persuade persons contemplating suicide to do so; (4) a state's interest in safeguarding the well-being and interests of those close to the person who commits suicide; (5) a state's interest in protecting the integrity of and reliability upon the medical profession as one persons may seek reliable assistance.

Amici would note for the Court on this occasion one central and compelling state interest and policy that should alone compel the rejection of respondents' cause. Proponents of

protecting the practice of physician assisted suicide, especially as a fundamental right protected by the Constitution, consistently point to the importance of respecting the autonomous decision-making power of the individual. Taken to its logical conclusion, however, such a policy provides no reasonable rationale why this choice should be provided only to the terminally ill. It is illogical to suggest that any other class of citizens may be prohibited from exercising this choice if it is granted to the terminally ill.[8]

Some will suggest that society ought to grant this choice of suicide only to the terminally ill out of respect for their unique plight and that the host of state interests identified heretofore continue to apply to the able-bodied among us. This is the very sort of decision which our constitutional structure confers upon the legislative branch, not the courts. In this context, the legislatures have determined that such an option ought not to be granted to the terminally ill for they recognize that "[s]ingling out the terminally ill as a class of people who 'deserve' to have their suicidal impulses respected...is logically incoherent unless one presupposes that, in some objective sense, their live[s are] not worth living. But, as a civilized society, we make no such claim with respect to any human being." Chopko, *Assisted Suicide*, 70 Notre Dame L.Rev. at 576.

The ancient lineage, outlined above, of the approach to the terminally ill found in traditional Jewish sources has made its way into our society's laws by way of its common Judeo-Christian heritage. While "[a]ncient lineage of a legal concept does not give it immunity from attack for lacking a rational basis," this Court has recognized that the very fact "[t]hat the law has long treated the classes as distinct...suggests that there is a commonsense distinction between [the two categories at issue.

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[8] The Ninth Circuit approvingly relied on this point in its first review of Washington's statute. 49 F.3d at 590-591 ([under this reasoning there is nothing to prevent] "the depressed twenty-one year old, the romantically devastated twenty-eight year old, [or] the alcoholic forty-year old" from also claiming a fundamental right to die.).

Heller, 113 S.Ct. at 2646. Thus, these laws of the State of New York and the State of Washington must be found to survive rational-basis review.

CONCLUSION

In its opinion below, the *Quill* court wondered "what interest can the state possibly have in requiring the prolongation of a life that is all but ended?" 80 F.3d at 729. The detached, doctrinal answer is that under a rational basis review it is the legislatures and not our courts which are to make such a determination. The more appropriate answer, and the one which *amici* ask this Court to resoundingly affirm, is that our nation, and its living Constitution, venerates and cherishes the value of every human life as our ancient traditions have for centuries.

For the foregoing reasons, the judgments of the Courts of Appeals should be reversed with instructions to enter judgments for the defendants.

Respectfully submitted,

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In the Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL KLAGSBRUN, M.D., AND HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

BRIEF OF SENATOR ORRIN HATCH, CHAIRMAN OF THE SENATE JUDICIARY COMMITTEE; REPRESENTATIVE HENRY HYDE, CHAIRMAN OF THE HOUSE JUDICIARY COMMITTEE; AND REPRESENTATIVE CHARLES CANADY, CHAIRMAN OF THE SUBCOMMITTEE ON THE CONSTITUTION OF THE HOUSE JUDICIARY COMMITTEE, AS AMICI CURIAE IN SUPPORT OF THE PETITIONERS

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NOVEMBER 12, 1996

QUESTION PRESENTED

Whether state laws prohibiting assisted suicide are unconstitutional.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

INTEREST OF THE AMICI 1

ARGUMENT 1

I. Assisted Suicide Involves Highly Contested Issues Of Morality And Public Policy, Which The Judiciary Is Ill-Suited to Resolve 2

A. Laws Against Assisted Suicide Are Supported By Serious And Substantial Ethical Justifications . . . 2

B. Constitutional Judicial Review Is Too Inflexible An Instrument For The Decision Of Such Questions . 10

II. The Decision Of The Ninth Circuit Is Antithetical To This Court's Traditional Approach To Interpreting The Fourteenth Amendment 15

A. The Fourteenth Amendment Takes Its Bearings From The Experience Of The Nation, Not From The Moral Intuitions Of Federal Judges 15

B. The Abortion Cases Should Serve As A Cautionary Note Rather Than A Precedent 22

C. The Asserted Right To Assisted Suicide Is Not A Fundamental Right Under The Fourteenth Amendment 24

CONCLUSION 29

TABLE OF AUTHORITIES

Cases **Pages**

Burnham v. *Superior Court*, 495 U.S. 604 (1990) 21

Carolene Products v. *United States*, 323 U.S. 18 (1944) 14, 15

Collins v. *City of Harker Heights*, 503 U.S. 115 (1992) 24

Commonwealth v. *Mink*, 123 Mass. 422 (1877) 28

Corfield v. *Coryell*, 6 Fed. Cas. 546 (1823) 17-21, 24

Cruzan v. *Missouri Dep't of Health*, 497 U.S. 261 (1990) 9

Dred Scott v. *Sandford*, 60 U.S. (19 How.) 393 (1857) 18

Erie R.R. Co. v. *Tompkins*, 304 U.S. 64 (1938) 19

Griswold v. *Connecticut*, 381 U.S. 479 (1965) 20, 21, 23

Hurtado v. *California*, 110 U.S. 516 (1884) 18-21, 25

Lochner v. *New York*, 198 U.S. 45 (1905) 19, 20

Marbury v. *Madison*, 5 U.S. (1 Cranch) 137 (1803) 15, 21

Meyer v. *Nebraska*, 262 U.S. 390 (1923) 20

Michael H. v. *Gerald D.*, 491 U.S. 110 (1989) 20

Moore v. *City of East Cleveland*, 431 U.S. 494 (1977) 20, 23

TABLE OF AUTHORITIES - Continued

Pages

Murray's Lessee v. *Hoboken Land and Improvement Co.*, 59 U.S. (18 How.) 272 (1856) 18-21, 24

Planned Parenthood v. *Casey*, 505 U.S. 833 (1992) 12, 21, 23, 24

Poe v. *Ullman*, 367 U.S. 497 (1961) 20, 21

Reno v. *Flores*, 113 S. Ct. 1439 (1993) 24, 26

Rodriguez v. *British Columbia (Attorney General)*, [1993], 3 S.C.R. 519 26

Roe v. *Wade*, 410 U.S. 113 (1973) 22, 23

Slaughter-House Cases, 83 U.S. (16 Wall.) 36 (1873) 16

Snyder v. *Massachusetts*, 291 U.S. 97 (1934) 20

State v. *Marti*, 290 N.W.2d 570 (Iowa 1980) 28

Statutes

720 Ill. Comp. Stat. Ann. § 5/12-31(a)(2) 25

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Iowa Code § 707A.2 25

Ky. Acts, ch. 269, § 2 (1994) 25

La. Rev. Stat. Ann. § 14:32.12 25

Mich. Comp. Laws Ann. § 752.1027 25

N.D. Cent. Code § 12.1-16-04 25

TABLE OF AUTHORITIES - Continued

Pages

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Aristotle, NICOMACHEAN ETHICS 27

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Calabresi, Guido, IDEALS, BELIEFS, ATTITUDES, AND THE LAW (1985) 23

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Gomez, Carlos F., REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991) 6

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Pages

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Pages

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INTEREST OF THE AMICI

These *amici curiae* have the honor of serving as chairmen of the Judiciary Committees of the United States Senate and House of Representatives, and of the Subcommittee on the Constitution of the House Judiciary Committee. In that capacity, the *amici* are directly concerned with the relationship of judicial and legislative authority under the Constitution. In addition, *amici* Hyde and Canady have conducted hearings on the subject of assisted suicide in the United States.

ARGUMENT

This *amicus curiae* brief is addressed to the most fundamental question of modern constitutional theory: When, and under what conditions, may courts invalidate duly enacted state or federal laws on the basis of unenumerated constitutional rights? Put differently: What are the respective roles of courts and legislatures in resolving contested questions of justice and political morality? On the one hand, we recognize that over the 209 years since adoption of the Constitution, the courts have, from time to time, exercised the power of judicial review in cases not compelled by the plain text of the Constitution, and rightly so. On the other hand, an unbridled power — whether called "substantive due process" or something else — to invalidate laws whenever five or more members of this Court deem them unwise or unjust would displace the legislative branch as the primary lawmaker. The purpose of this brief is to show that a principled middle ground exists, in which the courts may recognize and enforce constitutional rights in a fashion that gives due respect to the coordinate branches of government and the traditions of the people.

Under this approach, which is based on the text and history of the Fourteenth Amendment as well as leading precedents of this Court, the decisions of the courts below must be reversed. Assisted suicide is not, and never has been, recognized by this Nation as a protected constitutional right. In this brief, we focus on the due process argument of the Ninth Circuit, leaving the argument of the Second Circuit to others. But the institutional, prudential, and logical considerations we address apply to both decisions.

I. Assisted Suicide Involves Highly Contested Issues Of Morality And Public Policy, Which The Judiciary Is Ill-Suited to Resolve

A. Laws Against Assisted Suicide Are Supported By Serious And Substantial Ethical Justifications

We begin with a statement that may seem obvious, but must be the starting point for thinking about this constitutional controversy: the laws against assisted suicide have substantial moral and political justifications. These laws cannot be dismissed as arbitrary, antiquated, or unthinking.

Thoughtful and experienced doctors, ethicists, philosophers, lawyers, theologians, and advocates for patients have offered cogent reasons why assisted suicide should not receive the formal sanction of law. The professional associations in the disciplines closest to the problem — the American Medical Association, the American Psychological Association, the American Geriatric Society, and the American Bar Association among them — have all concluded that assisted suicide should not be made legal. The two most thorough and distinguished studies undertaken of the issue — one under the auspices of the State of New York and one under the auspices of the British House of Lords — both resulted in *unanimous* recommendations that laws against assisted suicide (as well as euthanasia) should be retained. New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994) [hereinafter cited as "NEW YORK REPORT"]; *Report of the Select Committee on Medical Ethics*, House of Lords, Sess. 1993-94. On April 29, 1996, the Subcommittee on the Constitution of the Committee on the Judiciary of the House of Representatives conducted hearings in which ethicists, physicians, legal experts, and specialists in the care of terminally ill, suffering, and disabled patients presented their perspectives on the issue. *Assisted Suicide in the United States:* Hearings Before the Subcommittee on the Constitution of the House Committee on the Judiciary, 104th Cong., 2d Sess. (1996) [hereinafter cited as "HOUSE HEARINGS"]. We commend those reports and hearings to this Court's attention.[1]

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[1] For the convenience of the Court, we have lodged copies of the HOUSE HEARINGS with the Clerk. We understand that copies of the New York and House of Lords reports have been lodged by others.

We will briefly summarize some of the reasons for prohibiting assisted suicide set forth in these sources, not because we believe the Court should resolve the underlying moral-political dispute, but because the lower courts' decisions were based on a mistaken belief that there are no plausible state interests (excluding religious dogma) in protecting the life of a terminally ill patient. In reaching their conclusions, the courts gave no deference to the nearly unanimous judgments of state legislatures and state courts, nor to the similar conclusions of distinguished ethicists, physicians, and others who have devoted their lives to the care of suffering patients. Judge Reinhardt's opinion for the Ninth Circuit dismissed contrary opinions as "cruel" (Pet. App. A75), "untenable" (*id.* at A76), "disingenuous and fallacious" (*id.* at A85), "meretricious" (*id.*), "ludicrous," (*id.*), and "nihilist" (*id.* at A98). The court praised its own view as "more enlightened" (*id.* at A76). The court characterized hundreds of years of common law precedent as "taboos," linked to superstition (*id.* at A46); brushed aside the central text of medical ethics, the Hippocratic Oath, saying that it "does not represent the best or final word on medical or legal controversies today" and that to follow it "literally" would be "preposterous" (*id.* at A95); and criticized arguments made by the American Medical Association and American Geriatric Society (among others) as reflecting "a misunderstanding of the proper function of a physician" (*id.* at A91). The sublime arrogance of these judicial pronouncements highlights the danger of allowing courts to set social policy, in defiance of legislatures and referenda, on the basis of their own (often ill-informed) philosophical intuitions.

Although there are many arguments in favor of laws prohibiting assisted suicide, we will summarize four of the most important.

First, even assuming *arguendo* that in a limited number of cases assisted suicide might be ethically permissible, many knowledgeable observers believe that the problems of abuse would be so widespread and uncontrollable that formal legal and ethical

prohibition remains necessary.[2] The harsh reality is that a more expeditious death for terminally ill patients would often serve the interests of others, especially in this era of managed care and exploding medical costs. A patient weakened by illness and pain is peculiarly susceptible to influence from family members or doctors who are in a position of trust. It will not be difficult for these individuals, for their own reasons, to exert subtle — but powerful — pressure on a frail patient to "choose" the convenient option of a speedy death. Even the suggestion by a well-meaning doctor that a patient should consider the option of death will inevitably convey the message that — in the doctor's informed professional opinion — her life is no longer worth living.[3]

For every suffering person who makes a rational, informed choice to die, there will be others — perhaps many times as many — on whom that "choice" is effectively imposed. And there will be no way to tell the difference.

Safeguards, no doubt, will be proposed. Indeed, the Ninth Circuit professed faith that "sufficient protections" can be enacted. Pet. App. A103-A104. Unfortunately, these were expressions of hope rather than descriptions of experience. Many physicians and ethicists doubt that effective safeguards can be devised or enforced — especially since typically no one involved in the death will have the incentive to expose wrongdoing, and the interactions involved are cloaked in the confidentiality of the doctor-client relationship. The American Medical Association's code of Medical Ethics, for example, rules out physician-assisted suicide partly on the ground

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[2] See NEW YORK REPORT, at xii, 102, 119-20, 140.

[3] See Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 113; Leon Kass & Nelson Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 409 (1996).

that it "would be difficult or impossible to control."[4] Even counsel for the respondents, Professor Tribe, has observed:

> [T]he judiciary's silence regarding [the right to determine when and how to die] probably reflects a concern that, once recognized, rights to die might be uncontainable and might prove susceptible to grave abuse * * * . [T]he resulting deference to legislatures may prove wise in light of the complex character of the rights at stake and the significant potential that, without careful statutory guidelines and gradually evolved procedural controls, legalizing euthanasia, rather than respecting persons, may endanger personhood.

Laurence H. Tribe, *American Constitutional Law*, § 15-11, at 1370-71 (2d ed. 1988).

The specter of widespread abuse and exploitation is not based on mere speculation. Studies of assisted suicide and euthanasia in the Netherlands, where safeguards are stringent on paper, show that those safeguards are routinely disregarded. Although medical guidelines recognize the right to die only based on the patient's own informed and voluntary decision, a survey of 300 physicians disclosed that over 40 percent had performed euthanasia *without* explicit consent. In 1990, in addition to 2,300 cases of active euthanasia with consent and 400 cases of assisted suicide, there were over 1,000 cases of active nonvoluntary euthanasia performed without the patient's knowledge or consent, including roughly 140 (14 per cent) where the patient was fully competent. Comparable rates of nonvoluntary euthanasia in the United States would be roughly 20,000 per year.[5] And these numbers do not even include

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[4] Opinion of the Council on Ethical and Judicial Affairs, American Medical Association, Opinion 2.211. For the most extensive discussion of these issues, see Daniel Callahan & Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1 (1996). See also NEW YORK REPORT, at 73; Testimony of Dr. Lonnie Bristow on behalf of the American Medical Association, HOUSE HEARINGS at 316-17 ("it is difficult to imagine adequate safeguards which could effectively guarantee that patients' decisions to request assisted suicide were unambivalent, informed and free of coercion"); Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 115.

[5] See John Keown, *Further Reflections on Euthanasia in the Netherlands in the Light of the Remmelink Report and the Var Der Maas Survey*, in Lucke Gormally,

cases where "consent" was extracted by means of undue influence, psychological coercion, or skewed information.

Giving choices to the vulnerable is not always liberating. A young woman is not more "free" if the law allows her to contract with a pimp; a young man is not more "free" if a pusher can sell him crack cocaine; a child is not more "free" if he or she can "consent" to sexual advances by adults; people are not more "free" if they can voluntarily sell themselves into slavery. Nor is an ill person necessarily more "free" if he can agree to kill himself. Indeed, the mere availability of assisted suicide as a socially-legitimated alternative may impel some who would prefer to live to accept this course out of feelings of guilt or shame about the burdens (financial and otherwise) that the choice of continued living would impose on their families. These laws are not an instance of some people "imposing their morality" on others. They result from citizens reflecting on the conditions that they may face at the end of life, and establishing rules that will protect all of us, when we are weakest and most vulnerable.

Second, if patients' requests for assistance in suicide are honored, many will die unnecessarily. According to medical experts, the desire to commit suicide (even among the terminally ill) is typically associated with clinical depression, which is a treatable disease.[6] The New York State Task Force reported: "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at time of death. Depression, accompanied by symptoms of hopelessness and helplessness, is the most prevalent condition among individuals who commit suicide." NEW YORK REPORT at 11; see also *id.* at 13 ("In one study of terminally ill patients, of those who expressed a wish to die, all met diagnostic criteria for major depression"); J.H. Brown, *et al.*, *Is It Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. of Psychiatry 208 (1986).

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ed., EUTHANASIA: CLINICAL PRACTICE AND THE LAW 193, 209, 221-25 (1994); Callahan & White, *supra*, 30 U. Rich. L. Rev. at 15-18. See also Carlos F. Gomez, REGULATING DEATH: EUTHANASIA AND THE CASE OF THE NETHERLANDS (1991); Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 106-13, 114-15.

[6] See Testimony of Dr. Herbert Hendin, HOUSE HEARINGS at 103-06.

When treated for depression, patients typically cease to desire suicide. NEW YORK REPORT at 26 (treatment of depression "resulted in the cessation of suicidal ideation for 90 percent of these patients").

Much of the desire to commit suicide is also traceable to insufficiently aggressive measures to alleviate pain.[7] When a suicidal patient is helped to deal with pain and depression, he or she typically is restored to the natural desire to live. To give patients the "right" to obtain assistance in suicide is to license the killing of persons who often are simply in need of help, which modern medicine can give. Professor Herbert Hendin, a professor of psychiatry at New York Medical College, testified:

> Patients who request euthanasia are usually asking in the strongest way they know for mental and physical relief from suffering. When that request is made to a caring, sensitive, and knowledgeable physician who can address their fear, relieve their suffering, and assure them that he or she will remain with them to the end, most patients no longer want to die and are grateful for the time remaining to them.

HOUSE HEARINGS at 115-16.

Since American doctors are notoriously uninformed about proper pain prevention techniques,[8] as well as depression,[9] it is almost certain that many people will be induced to die when instead they could receive effective palliative treatment.[10] The ethical

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[7] NEW YORK REPORT, at 16-17; Testimony of Dr. Lonnie Bristow on behalf of the American Medical Association, HOUSE HEARINGS at 309-10.

[8] NEW YORK REPORT, at 33 ("pain is often overlooked by health care providers"); *id.* at 43 ("the delivery of pain relief is grossly inadequate in clinical practice"); Testimony of Dr. Kathleen Foley, Chief of Pain Service at Memorial Sloan-Kettering Cancer Center, HOUSE HEARINGS at 18-20.

[9] NEW YORK REPORT, at 32; *id.* at 32-33 (study found that fewer than 15 percent of depressed residents of a nursing home for the elderly had been correctly diagnosed, and fewer than 25 percent had been treated for depression).

[10] See NEW YORK REPORT, at 40 ("modern pain relief techniques can alleviate

problem is magnified by the fact that economically disadvantaged patients and members of racial and ethnic minorities are the most likely to lack proper treatment for pain and depression,[11] and thus the most likely to "choose" — unnecessarily — to die. Other groups especially at risk are women and the elderly.[12]

Third, if death is defined as a "mercy," it will be difficult to justify refusing this mercy to broader and broader categories of sufferers. It is therefore misleading to confine one's attention (as the lower courts did) to "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors" (Pet. App. A116).[13] For example, the moral arguments supporting assisted suicide for terminally ill patients who are able to self-administer the killing agent apply just as strongly to similar patients who cannot do the deed for themselves. Thus, assisted suicide will merge into voluntary active euthanasia.[14] And the moral arguments supporting assisted suicide for the terminally ill apply with as much force — maybe more — to persons who face not a few weeks or months, but years of pain that seems to them intolerable. Thus, assisted suicide for the terminally ill will almost surely merge into assisted suicide for those with incurable chronic

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pain in all but extremely rare cases"); Testimony of Dr. Lonnie Bristow on behalf of the American Medical Association, HOUSE HEARINGS at 310, 314-15.

[11] NEW YORK REPORT, at 44, 46; Testimony of Dr. Carlos Gomez, House Hearings at 412.

[12] NEW YORK REPORT at 44; see also *id.* at 33.

[13] It is a striking example of the illogic of the decisions below that they declare the longstanding distinction between assisted suicide and refusal of life-sustaining treatment to be a distinction without a difference, only to propose new distinctions that have far less logical, empirical, or ethical justification. See Yale Kamisar, *The Right to Die: On Drawing (And Erasing) Lines*, 35 Duq. L. Rev. 481 (1996).

[14] *Id.* at 513-19; Dan W. Brock, *Voluntary Active Euthanasia*, Hastings Center Rep., Mar.-Apr. 1992. Indeed, the Ninth Circuit intimated that it did not regard the distinction between assisted suicide and active voluntary euthanasia as significant. Pet. App. A100-101.

conditions.[15] Persons with serious disabilities will be particularly at risk.[16] And (as cases like *Cruzan* so eloquently demonstrate), the argument for assisted suicide for competent adults will apply with seemingly equal force to those unable to consent for themselves, whose "right to die" will be exercised by surrogates. If death is seen as a mercy, why confine it to those fortunate enough to be able to consent? The same corrosive skepticism that the courts below evinced toward the distinction between refusal of treatment and active assisted suicide will be equally potent to dissolve all of the other limitations on this newfound right.

It is even difficult to understand why, under the reasoning of the Ninth Circuit, the mercy of assisted suicide should be denied to persons who, for reasons other than ill health, conclude that the suffering of life is unbearable. Physical pain and impending death are not the only — and not necessarily the most serious — reasons to desire a release from these mortal coils. Many of the examples in the lower court's opinion of suicide in other cultures involve suicide for reasons of honor, guilt, or grief. Pet. App. A40-A42. Patients are free to refuse life-sustaining treatment for any reason whatsoever. Once we conclude that death is a matter of personal autonomy — of privacy — where can we stop?[17]

Fourth, and most fundamentally, by making death a legally available "choice," we will inevitably change the way our culture perceives the final stages of life. When death is not an official option, the focus of the patient, the patient's family, the doctor, and the system is on what can be done to make the patient's life easier and better. If death becomes an approved social option, both the patient and the system will tend, instead, to focus on whether continued care is "worth it." The patient, aware of the burden she is imposing on loved ones, may well conclude that she "owes it"

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[15] See Kamisar, *supra*, 35 Duq. L. Rev. at 502-13.

[16] Testimony of Diane Coleman, in HOUSE HEARINGS, at 53-54; Statement of Diane Coleman and Carol Gill, *id.* at 53-70.

[17] The implications of this decision extend beyond assisted suicide and euthanasia. For example, what will be the effect on laws allowing the use of physical force to prevent suicide?

to her family to commit suicide. The decision to cling to life may come to be regarded as wasteful, irrational, and selfish. In the uniquely vulnerable circumstances of the lingering patient, the "right to die" will become, for many, the duty to die. See NEW YORK REPORT at 95. One blessing of the current law is that it relieves the elderly and the infirm of the need to justify their continued existence.

Even if the laws against assisted suicide are rarely enforced, they still have the effect of expressing society's deep commitment to the protection of human life. In combination with the ethical precepts of the medical profession, these laws ensure that assisted suicide remains a highly exceptional activity, rarely suggested or initiated by physicians. If assisted suicide is recognized as a "right," it will become both routinized and common. It is not obvious that patients would be better off.

These are among the reasons that have persuaded the New York legislature and the people of the State of Washington (along with most other states) to retain their laws against assisted suicide. These *amici* find the arguments compelling. We fear the consequence of the liberation of death, especially for the most vulnerable among us. But we do not ask this Court to adopt our view of the moral consequences of legalized assisted suicide. Indeed, the point we wish to make is that this case should not be decided on the basis of the Justices' own assessment of the weight of the competing moral arguments. Rather, as members of the legislative branch of government, we maintain that this is not a question for courts to decide — or more precisely, that there is no legitimate basis in the Constitution of the United States for overturning the laws that have been enacted by the various states on this issue.

B. Constitutional Judicial Review Is Too Inflexible An Instrument For The Decision Of Such Questions

Even apart from the specifics of constitutional doctrine, there is every reason for courts to be wary about overturning duly enacted legislation on the basis of untried and uncertain moral and philosophical arguments, where the result is bereft of support in directly relevant constitutional text or in national experience. It may well be true that attitudes about the end of life have changed,

or will change, in response to technological developments and their attendant economic and emotional consequences. But it would be a grave mistake for the federal courts to leap in and attempt, prematurely, to resolve the issue or to accelerate the pace of change. Even on the heuristic assumption that laws against assisted suicide and euthanasia should be relaxed (which these *amici* doubt), it is better that reform take place in decentralized and accountable institutions.

The great institutional strength of courts is their ability to provide uniform enforcement of legal principles, with consistency across parties, regions, and time periods, treating like cases alike. Where operative principles are in flux and the consequences of new approaches are unpredictable, however, that virtue becomes a vice. Constitutional judicial review is too inflexible a process to deal sensitively and appropriately with a matter such as this.

First, by locating the right to die in the federal constitution, the courts below nationalized the issue and eliminated the possibility of state variation and experimentation. Justice Brandeis's characterization of the states as "laboratories of democracy" is no cliche; it is an apt description of one of the principal virtues of a federal system. In this case, there is no serious argument that national uniformity is necessary or even desirable. The State of Oregon has undertaken an experiment in physician-assisted suicide that — however misguided it may appear to many of us — will cast light on the practical consequences: on the efficacy of the safeguards against abuse, on the ability of the medical profession to recognize and treat clinical depression and pain in patients requesting suicide, on the robustness of the lines drawn between permitted and forbidden forms of the right to die, and on the danger that death will come to be perceived as a duty owed to family and society. To treat this social policy question as controlled by federal constitutional law is to eliminate the possibility of a multiplicity of approaches, and of regional variation in light of differences in social and moral perceptions.

Even a leading advocate of physician assisted suicide, and sometime co-author with respondent Quill, has recognized that the right to die should be the subject of legislative reform rather than judicial fiat:

> Legalization of physician assisted suicide should be understood not as a matter of recognizing rights but as a policy aimed at making available a compassionate option of last resort for competent, terminally ill patients. Since we do not know whether such a policy will produce more good than harm, it should be viewed as an experiment.
>
> Our federal system of government has often been touted as offering "a laboratory of the states," with which to experiment concerning social policy. In the case of a morally controversial issue, subject to competing arguments pro and con, it is better that policy experimentation occur piecemeal, by the various decisions of the legislatures or voters of the states, rather than wholesale, by means of the constitutional adjudication of the federal courts.

Franklin G. Miller, *Legalizing Physician-Assisted Suicide by Judicial Decision: A Critical Appraisal*, 2 BioLaw S:136, S:144 (Special Section, July-Aug. 1996).

Second, by their nature constitutional judicial decisions must be "grounded truly in principle"; they may not be "compromises with social and political pressures." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 865 (1992). The lines drawn by courts, under the authority of the Constitution, must be defensible at the level of constitutional principle.

Yet not every aspect of social life can be governed by crisp and principled rules. Sometimes, the best and most peaceful solution to contentious moral conflicts in society is not to award the brass ring to one side or the other, but to construct compromises that allow each contending force to believe that the system has been responsive to their deeply held convictions. Legislatures are good at that. Whatever one may think of legislators as moral deliberators, few would dispute that they have the expertise and incentive to resolve social conflict in a way that minimizes political opposition and resistance. The legislative answer may not appear pure from a philosophical or analytical perspective, but it is likely to reduce social discord. And even if legislatures prove unable to forge a stable consensus, contending social forces are more likely to accept the outcome of a process in which their voices were heard

than an imposed solution in which their elected representatives were not entitled to a significant role.

The right to die may well be such an issue. Certainly, the public is seriously divided. Passions run high. The various lines that might be drawn — refusal of treatment versus suicide, assisted suicide versus active euthanasia, terminal illness versus chronic pain or disability, actual consent versus imputed consent, intolerable pain versus other conditions that harm the quality of life, one set of safeguards versus another, and so forth — are, each of them, arbitrary in their own way. Each of them attempts to allow the dying patient some greater degree of control over the circumstances of his death, while at the same time upholding the society's obligation to honor life and protect the vulnerable. Each tries to reconcile two honorable impulses that are, in principle, irreconcilable: autonomy and protection. Prudential compromises are difficult to justify as interpretations of the Constitution, but are the everyday product of legislative action.

Third, and most importantly, courts are seriously constrained in their ability to change their policy in response to experience and criticism. Each decision of the Court is said to be based on an interpretation of the Constitution, and it strains public credulity that the meaning of such an old document would change very rapidly, very often. The doctrine of *stare decisis* thus creates a presumption in favor of existing doctrine. Stability is a source of judicial strength and legitimacy. But with this strength comes a caution: just as the Court is properly reluctant to jettison a constitutional doctrine that it has embraced, the Court should be reluctant to embrace novel constitutional doctrines that may require modification in the future.

This case is a perfect example. If the Court joins the lower courts in creating a right to assisted suicide, neither Congress nor the states will be able to explore contrary policies. If that judgment proves to be misguided, great injury will have been done to thousands of vulnerable persons, in every state in the Union, until the Court brings itself to acknowledge the mistake and reverse the decision. On the other hand, if the Court reverses the judgments below, debate on the issue will proceed. The several states will be free to pass laws allowing assisted suicide or euthanasia in such circumstances and under such safeguards as they may deem

advisable. If experiments with liberalized laws on this subject are successful, it is likely that still more states will follow suit. If they prove misguided (as we expect), these states can reverse course, and the other states will profit by their example.

One final observation about the institutional capacities of courts and legislatures bears mention. Since the *Carolene Products* decision, prominent strains of constitutional theory have maintained that the judiciary should be most willing to intervene in cases where the adverse consequences of the challenged law are borne by discrete and insular minorities whose interests may not have received their just weight in legislative deliberations. See generally John Hart Ely, DEMOCRACY AND DISTRUST (1980). Whatever the merits of that view, we wish to stress that it has no application to this case. When the New York legislature decided to retain its laws against assisted suicide, or the people of Washington made a similar decision by referendum, they were not legislating for a discrete and insular minority. They were legislating for themselves and for their loved ones, behind a veil of ignorance that denies all of us the knowledge of what our condition may be in the final days of our lives. There is no reason to distrust the conclusions that they reached.

If anything, the biases of the political process run the other way: in favor of fewer protections against euthanasia than may be in the best interests of those immediately affected by the law. Studies indicate that the frail elderly, who are most likely to feel the effects of the law in this area, are significantly less likely to favor legalizing assisted suicide than the young and healthy. Harold G. Koenig, et al., *Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide*, 156 Archives of Internal Med. 2240 (Oct. 28, 1996) (only 34% of elderly outpatients favor legalizing physician-assisted suicide, as compared to 55.6% of their families; female, black, and economically disadvantaged patients were most likely to oppose it). This is not surprising. From the vantage point of youth and health, the quality of life enjoyed by disabled, chronically ill, or dying people appears excruciatingly low. But persons experiencing those conditions, whose point of comparison is not youth and health but death, often cling to life with increased tenacity. Self-interest, both individual on the part of family members and collective on the part of health

care providers, also plays its part in shaping opinion on this issue. The logic of *Carolene Products*, in this context, is that courts should be more active in ensuring that the protections against unwanted death are adequate than in ensuring that the political process is sufficiently receptive to the right to die.

II. The Decision Of The Ninth Circuit Is Antithetical To This Court's Traditional Approach To Interpreting The Fourteenth Amendment

A. The Fourteenth Amendment Takes Its Bearings From The Experience Of The Nation, Not From The Moral Intuitions Of Federal Judges

Constitutional judicial review had its birth in the recognition that a written constitution reflects the limits that the people of the United States have placed upon their government. *Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137, 176 (1803). It was no part of the theory of judicial review that the courts are superior to the people in their judgments of what those limits should be. It is revealing that the examples deployed by Chief Justice Marshall in his great exposition of the theory of judicial review consisted of explicit limitations unambiguously violated by the government. *Id.* at 178. In such cases, it was clear that judicial review served to enforce the will of the people rather than the will of the judiciary.

Nonetheless, in the 209 years since the Constitution was adopted, this Court has not infrequently held unconstitutional acts of the political branches that do not violate any express provision. The most common basis for so doing is the Due Process Clause of the Fourteenth Amendment. This presents a jurisprudential problem: The very language of the Due Process Clause, which forbids the denial of life, liberty, or property *without* due process of law, necessarily implies that states *may* deny life, liberty, and property if due process of law is provided — unless some other provision of the Constitution is implicated. The notion of "substantive due process," as many distinguished commentators have pointed out, is an oxymoron — like "green pastel redness," in the famous comment of John Hart Ely. *Democracy and Distrust*, *supra*, at 18.

From the perspective of text and history, the Privileges or Immunities Clause of the Fourteenth Amendment would appear to

be a more plausible basis for the protection of substantive rights (whether incorporated from the Bill of Rights or based on other sources) than the Due Process Clause. See *id.* at 22; Philip B. Kurland, *The Privileges or Immunities Clause: "Its Hour Come Round At Last?"*, 1972 Wash. U. L. Q. 405, 419. It provides that "[n]o state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States." As discussed below, the language "privileges or immunities" was a legal term of art that also appears in the Comity Clause of Article IV, and that had been interpreted as referring to the essential rights and freedoms recognized in the American constitutional tradition.[18]

Why does this matter? Any constitutional jurisprudence of substantive rights, if conducted under the rubric of the Due *Process* Clause, must necessarily appear to be based on something other than constitutional text and the authentic purpose of the Fourteenth Amendment — indeed, such a jurisprudence will appear to have been created by judges with no delegation of constitutional authority by the people. Not only does this give the very idea of

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[18] This would require reconsideration of the reasoning (though not necessarily the result) of the *Slaughter-House Cases*, 83 U.S. (16 Wall.) 36 (1873), which reduced this Clause to the redundancy of protecting only those rights already protected under the Constitution and arising as a matter of federal citizenship. But the overwhelming weight of historical and scholarly opinion is that *Slaughter-House* was wrong in this regard. See, *eg.*, Akhil R. Amar, *The Bill of Rights and the Fourteenth Amendment*, 100 Yale L. J. 1193, 1257-59 (1992); Raoul Berger, GOVERNMENT BY JUDICIARY: THE JUDICIAL TRANSFORMATION OF THE FOURTEENTH AMENDMENT 37-49 (1977); Michael Kent Curtis, NO STATE SHALL ABRIDGE: THE FOURTEENTH AMENDMENT AND THE BILL OF RIGHTS 175-77 (1986); John Harrison, *Reconstructing the Privileges or Immunities Clause*, 100 Yale L.J. 1385, 1466-69 (1992); Walter E. Murphy, Slaughter-House, *Civil Rights, and the Limits on Constitutional Change*, 1987 Am. J. of Jurisprudence 1, 1-8 (1987); William E. Nelson, THE FOURTEENTH AMENDMENT: FROM POLITICAL PRINCIPLE TO JUDICIAL DOCTRINE 156-64 (1988). A rare exception to this scholarly consensus is Robert Bork, THE TEMPTING OF AMERICA: THE POLITICAL SEDUCTION OF THE LAW 36-39 (1990).

For an explanation by the author of this brief of the reasons why *Slaughter-House* was inconsistent with the text and original meaning of the Fourteenth Amendment, see Michael W. McConnell, *Originalism and the Desegregation Decisions*, 81 Va. L. Rev. 947, 999-1000 (1995).

judicial protection of rights not specified by the text an undeserved aura of illegitimacy, it also — and more importantly — deprives us of a textual or historical basis for distinguishing between responsible and irresponsible exercises of that judicial power. Once it is recognized that the Privileges or Immunities Clause authorizes protection for rights *understood in a particular way*, there is a solid basis for distinguishing between legitimate and illegitimate uses of that power.

Although the Due Process Clause is essentially about process and the Privileges or Immunities Clause is essentially about substantive rights, the underlying principles and methodologies for application are consistent and complementary. The task of interpretation is greatly eased by the fact that each Clause had its counterpart in the Bill of Rights and Article IV, respectively, and each had been authoritatively interpreted at the time those terms were used in the new Fourteenth Amendment. When the framers of the Fourteenth Amendment used familiar legal terminology, it may be inferred that the terms were intended to be interpreted in light of then-prevailing doctrine.

The leading case interpreting the Privileges and Immunities Clause of Article IV in the years prior to the Civil War was *Corfield* v. *Coryell*, 6 Fed. Cas. 546 (1823), written by Justice Bushrod Washington on circuit. The court defined the privileges or immunities of citizens as consisting of:

> those privileges and immunities which are, in their nature fundamental; which belong, of right, to the citizens of all free governments; and which have, at all times, been enjoyed by the citizens of the several states which compose this Union, from the time of their becoming free, independent, and sovereign.

In other words, these "fundamental" rights[19] had two characteristics: (1) they were recognized by "all free governments,"

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[19] It should be noted that the term "fundamental" rights did not necessarily mean rights that are especially important. Rather, in England, America, and western Europe, "fundamentality" most often referred to the character of being long-standing or ancient. See J.G.A. Pocock, THE ANCIENT CONSTITUTION AND THE FEUDAL LAW 30-36, 47-55 (1957); J.W. Gough, FUNDAMENTAL LAW IN ENGLISH CONSTITUTIONAL HISTORY 160 (1955).

and (2) they had been enjoyed by citizens "of the several states" from the beginning of the Republic. *Corfield* was repeatedly cited by proponents of the Fourteenth Amendment to explain what rights the new Amendment would protect.[20]

The leading case interpreting the Fifth Amendment Due Process Clause prior to the Civil War was *Murray's Lessee v. Hoboken Land and Improvement Co.*, 59 U.S. (18 How.) 272 (1856). In that case, Justice Benjamin Curtis (later to be the leading dissenter in *Dred Scott*) offered the following methodology for determining what "due process" entails in any particular case:

> We must examine the constitution itself, to see whether this process be in conflict with any of its provisions. If not found to be so, we must look to those settled usages and modes of proceeding existing in the common and statute law of England, before the emigration of our ancestors, and which are shown not to have been unsuited to their civil and political constitution by having been acted on by them after the settlement of this country.

In the first important due process case after ratification of the Fourteenth Amendment, *Hurtado* v. *California*, 110 U.S. 516 (1884), the Court reiterated this interpretation. This formulation suggests that due process embodies (1) explicit constitutional provisions, plus (2) long-established procedural rights ("modes of proceeding") that had existed in America from the beginning.

These two clauses of the Fourteenth Amendment thus have two common features. First, they take their bearings from the long-established rights and procedures of the American states. They are, accordingly, *preservative* rather than *transformative*. They are guarantees against unwarranted and unwise innovation; they are not invitations to judicially-mandated social change. This does not mean that the rights protected by these clauses are frozen in time. They may change as society changes. But before a claim may be accepted as a Fourteenth Amendment right, and imposed on the people of all the states, it must have withstood the test of time.

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[20] See, *e.g.*, Cong. Globe, 39th Cong., 1st Sess. 1835-36 (Apr. 7, 1866) (Rep. Lawrence); *id.* at 474-75 (Jan. 29, 1866) (Sen. Trumbull); *id.* at 2765 (May 28, 1866) (Sen. Howard).

The Fourteenth Amendment is not a license for judicial social experimentation.

Second, the two Clauses have the effect (as intended by the framers of the Fourteenth Amendment) of nationalizing the question of rights. Prior to the Fourteenth Amendment, the states were the principal locus of rights protection. Thus, the privileges and immunities of Americans were described in Article IV as "Privileges and Immunities of Citizens *in the several States*"; but in the Fourteenth Amendment these rights became known as "privileges or immunities of citizens *of the United States*." Moreover, under the new Amendment the power of the United States was deployed to prevent any state from abridging these rights, even as to its own citizens. Thus, the concept of rights became national. As John Bingham of Ohio, principal author of the Amendment, explained, it "protect[s] by national law the privileges and immunities of all the citizens of the Republic and the inborn rights of every person within its jurisdiction whenever the same shall be abridged or denied by the unconstitutional acts of any State." Cong. Globe, 39th Cong., 1st Sess. 2542 (1866).[21]

In practice, as interpreted by *Corfield*, *Murray's Lessee*, and *Hurtado*, this means that an individual may challenge the denial of any right that has been recognized by a sufficiently large number of states for a sufficiently long period of time that it can truly be said to be part of the fabric of American liberty. (Analogies might be drawn to the process of divining customary international law from the established practices of many states, or of determining the general common law in the period before *Erie R.R. Co.* v. *Tompkins*, 304 U.S. 64 (1938).)

In the years since *Corfield*, *Murray's Lessee*, and *Hurtado*, this Court has sometimes exceeded the authority implied by those cases, and has invalidated legislation without valid warrant in either express constitutional provisions or the settled judgment of the Nation. The most obvious examples are the decisions known as "the *Lochner* era." In other decisions, which have gained in respect

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[21] For further elaboration of this point, see Michael W. McConnell, *The Fourteenth Amendment: A Second American Revolution or the Logical Culmination of the Tradition?*, 25 Loy.-L.A. L. Rev. 1159, 1164-68 (1992).

and influence over the years, the Court has defined the reaches of unenumerated rights in terms not dissimilar to those in *Corfield*, *Murray's Lessee*, and *Hurtado*.

In his prescient dissent in *Lochner* v. *New York*, 198 U.S. 45, 76 (1905), Justice Holmes argued that instead of deciding the case on the basis of their own economic theories, the Justices should rely on "fundamental principles as they have been understood by the traditions of our people and our law." This approach was embraced by the Court in *Snyder* v. *Massachusetts*, 291 U.S. 97 (1934). In that case, Justice Cardozo explained that the Fourteenth Amendment protects rights "so rooted in the traditions and conscience of our people as to be ranked as fundamental." *Id.* at 105. See also *Meyer* v. *Nebraska*, 262 U.S. 390, 399 (1923) (recognizing "those privileges long recognized at common law as essential to the orderly pursuit of happiness by free men"); *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (plurality by Powell, J.) ("the Constitution protects the sanctity of the family precisely because the institution of the family is deeply rooted in this Nation's history and tradition"); *Michael H.* v. *Gerald D.*, 491 U.S. 110 (1989) (plurality).

Perhaps the leading statement of this approach in the modern period was Justice Harlan's dissenting opinion in *Poe* v. *Ullman*, 367 U.S. 497, 542 (1961), later to form the basis for his opinion in *Griswold*:

> Due process has not been reduced to any formula; its content cannot be determined by reference to any code. The best that can be said is that through the course of this Court's decisions it has represented the balance which our Nation, built upon postulates of respect for the liberty of the individual, has struck between that liberty and the demands of organized society. If the supplying of content to this Constitutional concept has of necessity been a rational process, it certainly has not been one where judges have felt free to roam where unguided speculation might take them. The balance of which I speak is the balance struck by this country, having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing.

Harlan did not engage in speculative inquiries about what freedoms he deemed most important to human life. Rather, he asked the concrete question: how has the asserted right been treated by the 50 states and by other nations? In the case of laws prohibiting the use of contraceptives, Harlan found "conclusive" the "utter novelty of this enactment." *Poe*, 367 U.S. at 554-55; see also *Griswold*, 381 U.S. at 499. Neither the federal government, any other state, nor any other nation, he found, "has made the *use* of contraceptives a crime." *Poe*, 367 U.S. at 554.

If Harlan's interpretive method departs from that in *Corfield*, *Murray's Lessee*, and *Hurtado*, it is solely in his emphasis on tradition as a "living" thing. It is not necessary, Harlan seems to be saying, that the tradition have existed unbroken from the time of the Founding. It is sufficient — as his analysis in *Poe* and *Griswold* bears out — that a substantial consensus of the states had recognized the right for a period long enough that it came to represent the will of the Nation.[22]

Harlan's central insight is that constitutional judicial review under the Due Process Clause *must not be based on the judges' own "unguided speculation."* Accord, *Casey*, 505 U.S. at 849 (the fact that the boundaries of substantive due process "are not susceptible of expression as a simple rule * * * does not mean that we are free to invalidate state policy choices with which we disagree"). The judges must, instead, seek the "balance" that "*our Nation*" has struck. This does not mean that judges are entitled to don the robe of the philosopher king and second-guess the decisions of legislatures. As in *Marbury*, there is no suggestion that the judges are superior to the people in their capacity to determine the proper restraints on government. The judges instead must enforce

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[22] The necessity of viewing tradition as a "living" thing was reaffirmed in *Burnham* v. *Superior Court*, 495 U.S. 604 (1990) (plurality per Scalia, J.). In *Burham*, the Court explained that when traditionally approved procedures have been abandoned by all but "a very small minority of the States," they become vulnerable to due process challenge, however "traditional" they may once have been, but where the challenged practice "is both firmly approved by tradition and still favored," it cannot be said to violate due process. *Id.* at 622; see also *id.* at 615 (noting that the challenged pracatice is "not only old; it is continuing").

the will of the people as it is reflected in the traditions which they have developed, as well as the traditions from which they broke.

This approach makes sense because judicial interpretations based on longstanding customs and practices are grounded — like the text of the Constitution itself — in the will of the people; because longstanding experience — in contrast to philosophical speculation — provides a sound empirical basis for reasoned judgment; and because the legal terms used by the framers of the Fourteenth Amendment were understood at that time to be references to long-established rights and privileges. The contrasting approach, adopted by the courts below, divorces itself from popular will, replaces the experience of history with judicial whim, and has no legitimate basis in the history and political theory of the Fourteenth Amendment.

B. The Abortion Cases Should Serve As A Cautionary Note Rather Than A Precedent

There is only one significant area in which this Court has departed from this approach to the Due Process Clause: the abortion cases. In *Roe* v. *Wade*, 410 U.S. 113 (1973), this Court struck down a state law prohibiting abortion notwithstanding the fact that such laws had been in place in at least 45 states for at least 100 years. The Ninth Circuit relied heavily on those cases. Pet. App. A25-A28, A56-A58.

Strictly as a matter of precedent, the Ninth Circuit's reliance was misplaced.[23] Essential to the holding of *Roe* was the conclusion that fetuses or unborn children are not constitutional "persons" and that their status as persons was beyond the ken of court or legislature. 410 U.S. at 158-59. By contrast, no one has questioned the indubitable fact that the patients involved in these cases are persons in every sense of the word. The *Roe* holding that fetuses, as non-persons, fall outside of the state's legitimate role of protection says nothing about the proper disposition of this case. Moreover, in the years since *Roe*, many commentators have come to the conclusion that the abortion right is more plausibly predicated on the fact that abortion laws bear most heavily on

[23] See generally Seth Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay on Roe, Casey, and the Right to Die*, 44 Am. U. L. Rev. 803 (1995).

women and thus raise a problem of sex discrimination.[24] Whatever one may think of that argument, it has no application to these cases, which involve laws that potentially apply to every one of us, without distinction.

The Ninth Circuit found "highly instructive" and "almost prescriptive" (Pet. App. A57) language from the *Casey* plurality opinion that referred to "the most intimate and personal choices a person may make in a lifetime," and which stated: "At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.*, quoting *Casey*, 505 U.S. at 851. With all respect to the Ninth Circuit, those quotations will not bear the weight put on them.

Like other highly generalized formulations about liberty — for example, the "right to be left alone" — the statement in *Casey* cannot be understood literally, as "prescriptive" of specific rights. The statement is so general and abstract that it could mean anything or nothing. It surely does not mean that every intimate or personal choice is constitutionally protected. Rather, it must be read in the context of the opinion as a whole. In light of the plurality's emphasis on the "unique" character of the abortion decision (*id.* at 852), it is untenable to stretch these statements to cover the entirely different context of assisted suicide.

This Court has cited *Roe* in support of a new substantive due process right only once since *Roe* was decided 23 years ago, and that case was amply supported by traditional due process methodology. *Moore* v. *City of East Cleveland*, *supra*.[25] In the

[24] See, *e.g.*, Guido Calabresi, IDEALS, BELIEFS, ATTITUDES, AND THE LAW 99-102 (1985); Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1199-1202 (1992); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. Rev. 375, 382, 386 (1985); Martha Minow, MAKING ALL THE DIFFERENCE: INCLUSION, EXCLUSION AND AMERICAN LAW 56-60 (1990); Cass R. Sunstein, THE PARTIAL CONSTITUTION 270-85 (1993); Laurence H. Tribe, ABORTION: THE CLASH OF ABSOLUTES 105 (1990); see also Richard Posner, SEX AND REASON 339-40 (1992) (noting that the "focus" of *Roe*'s defenders has "shifted to the equal protection clause").

[25] *Roe* has been cited in several cases involving the right to contraceptives, but in light of *Griswold* these cannot be said to be new substantive due process rights. It has also been cited in several equal protection cases.

meantime, the Court has refused to recognize asserted rights to engage in acts of homosexual sodomy, of patients to choose their own form of medical treatment, of a father to enjoy visitation rights with his child born of an adulterous relationship, of prisoners to contact visits while in pretrial detention, of unrelated persons to share a home together, of a person to be free from governmental distribution of derogatory information about himself, of a psychiatric patient to be free from compulsory hospitalization, of an employee to be warned of workplace hazards, and of juvenile aliens to be placed in noncustodial settings. Far from suggesting that the abortion cases justify an expansion of substantive due process into other matters of great personal importance, these decisions show that the Court has been extraordinarily reluctant to extend the precedent. *Collins* v. *City of Harker Heights*, 505 U.S. 115, 125 (1992); *Reno* v. *Flores*, 507 U.S. 282, 302 (1993). This vitiates any plausible claim that the abortion precedents compel recognition of a right to assisted suicide.

More fundamentally, we submit that the abortion cases should not be treated as an unalloyed success, to be imitated in other areas of our national life. While this Court has decided to adhere to the fundamental holding of *Roe* for reasons of *stare decisis* and settled expectations (*Casey*, 505 U.S. at 854-69), it is apparent to many (even to supporters of the "right to choose") that the Court's sweeping decision, at one stroke, to invalidate the laws of almost every state on a matter that is deeply controversial among the people of this nation, was of questionable legitimacy and even more questionable prudence. Now, almost a quarter century after the *Roe* decision, the abortion question continues to be the most divisive in American politics, poisoning everything from presidential nominating conventions to the confirmation hearings of Supreme Court Justices. Many supporters of abortion rights believe that those rights would have been achieved with less contention and greater public acceptance if the matter had been left to the political process, as in other Western nations. There is no reason to repeat those mistakes in this context.

C. The Asserted Right To Assisted Suicide Is Not A Fundamental Right Under The Fourteenth Amendment

The decision of the Ninth Circuit is antithetical to the traditional approach outlined in *Corfield*, *Murray's Lessee*, and

Hurtado and articulated more fully by Justice Harlan. The claim of a right to assisted suicide may be a respectable philosophical position, but it has absolutely no foundation in the explicit provisions of the Constitution or in the balance "our Nation" has struck.

Assisted suicide is prohibited by statute in 35 states and by common law in 11 more.[26] In only one state, Oregon, is it expressly permitted, and then only recently. These laws reflect a longstanding common law tradition against allowing suicide in any form. Even the Ninth Circuit traces the common law prohibition of suicide to the 13th Century, acknowledges that the Western treatment of suicide as a crime persisted for 1,000 years, and admits that the medical ethical prohibition of assisting suicide dates to the time of Hippocrates. Pet. App. A44-A45, A94. The tradition embodied by these laws is — moreover — a "living" one. Nine states have strengthened their statutory prohibitions in the past five years.[27] State legislatures in an additional 15 states[28] have debated the issue since 1991, and all have decided to retain their laws. Referenda proposing legalization of assisted suicide have been rejected by the voters of California and Washington (though accepted by the voters of Oregon). The courts of at least 17 states, interpreting their common law, have distinguished assisted suicide

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[26] Citations to these statutes and decisions may be found in footnotes 12, 13, and 14 of the *Brief Amicus Curiae on Behalf of Members* of the New York and Washington State Legislatures.

[27] 720 Ill. Comp. Stat. Ann. § 5/12-31(a)(2) (effective Aug. 29, 1993); Ind. Code Ann. § 35-42-1-2.5(b) (approved Apr. 30, 1993); Iowa Code § 707A.2 (approved Mar. 1, 1996); 1994 Ky. Acts, ch. 269, § 2 (effective July 7, 1994); La. Rev. Stat. Ann. § 14:32.12 (effective June 16, 1995); Mich. Comp. Laws Ann. § 752.1027 (effective Mar. 31, 1993); N.D. Cent. Code § 12.1-16-04 (effective July 1995); R.I. Gen. Stat. tit. 11, § 60 (approved 1996); Tenn. Code Ann. 39-13-216 (approved 1993).

[28] Alaska, Arizona, California, Colorado, Connecticut, Maine, Maryland, Massachusetts, Mississippi, Nebraska, New Hampshire, New Mexico, Vermont, Washington and Wisconsin.

from the established right to refuse treatment.[29] The American Medical Association, the American Geriatric Society, the American Psychological Association, and the American Bar Association, have all debated the issue in recent years and declined to endorse legalization. Interdisciplinary task forces in New York and Great Britain have unanimously voted to retain laws against assisted suicide. The drafters of the Model Penal Code retained prohibitions against assisted suicide without any exceptions. MODEL PENAL CODE § 210.5(2) (Official Draft and Revised Comments 1980). The Supreme Court of Canada has rejected an asserted right to assisted suicide. *Rodriguez* v. *British Columbia (Attorney General)*, [1993], 3 S.C.R. 519. No unreversed courts — other than the courts below — have ever accepted such a claim.

In the face of this nearly unanimous tradition, which enjoys considerable support to this day, it is simply disingenuous to claim that assisted suicide reflects the balance that "our Nation" has struck. It represents nothing other than the balance that the judges on the Ninth and Second Circuits have struck. See *Reno* v. *Flores*, 507 U.S. at 303 (citations omitted) ("The mere novelty of such a claim is reason enough to doubt that 'substantive due process' sustains it; the alleged right certainly cannot be considered 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'").

The Ninth Circuit opinion is virtually a parody of proper constitutional analysis under the Fourteenth Amendment. In contrast to Justice Harlan's insistence that rights must be grounded in historical experience, the Ninth Circuit declared that "earlier legislative or judicial recognition of the right or interest is not a sine qua non" (Pet. App. A35). Remarkably, in its survey of "Historical Attitudes Toward Suicide," the court below disregarded unbroken and virtually unanimous state practice in favor of a combination of inapposite ancient views and modern polling data. The court began with "ancient attitudes," in which suicide "was

[29] Citations may be found in the *Brief Amicus Curiae on Behalf of Members* of the New York and Washington State Legislatures, at 24-27 & n.25.

often considered commendable." Pet. App. A40.[30] The court was unperturbed by the fact that, by its own evidence, suicide was commended in cases of dishonor, grief, guilt, and weariness of life. Pet. App. A40-A42; see also *id.* at A41 ("The Stoics glorified suicide as an act of pure rational will."). Since not even the Ninth Circuit thinks we should go that far, this glorification of suicide would appear to be a tradition from which we have broken, rather than one that reflects "our Nation's" balance between liberty and the demands of organized society. It is a strange basis for saying that modern statutes, reflecting the modern respect for life, are unconstitutional.

After devoting several paragraphs to the early Christian martyrs (who did not commit "suicide" as it is ordinarily understood, but simply worshipped God and paid the price), the court grudgingly acknowledged — *in one clause of one sentence* — that the "view that suicide was in all cases a sin and crime held sway for 1,000 years" (Pet. App. A44). The court moved quickly to the more convenient fact that some "philosophers, poets, and even some clergymen" began to dissent in the 17th century. *Id.*

[30] Although space will not permit us to engage in a debate with the court below over its reading of historical sources, the observant reader cannot fail to notice the one-sided and selective nature of the court's account. For example, the court invoked the distinguished name of Plato in support of the practice of suicide, (Pet. App. A41), but failed to mention that Aristotle, no less impressive an authority, took the view that suicide was unjust under all circumstances. Aristotle, NICOMACHEAN ETHICS, chap. 5, 1138a. Similarly, while the court's statement that suicide was not "universally prohibited" in Greek times and was sometimes "considered commendable" (Pet. App. A40) is literally true, it might have been more balanced to acknowledge that, according to the historian on whom the court relied, suicide was generally disfavored, and euthanasia was not practiced. A. Alvarez, THE SAVAGE GOD 58 (1971), discussed in the NEW YORK REPORT, at 78 & n.5. Most strikingly, the court cited seven poets and philosophers of the early modern period who "challenge[d] the all-encompassing nature of the dominant ideology" (Pet. App. A44) — failing to mention that such luminaries as John Locke and Immanuel Kant (among others) defended the traditional ban on suicide. See NEW YORK REPORT, at 81.

In short, while the Ninth Circuit's historical survey is not literally inaccurate, its selective use of evidence seems designed to suggest that suicide enjoyed more support in past ages than it actually did. The court's pejorative reference to "the dominant ideology" (Pet. App. A44) effectively concedes that the anti-suicide tradition was, in fact, "dominant."

The court also drew comfort from the fact that, on the eve of the Reign of Terror, the revolutionary regime in France legalized suicide. *Id.*

Unable to gainsay the common law prohibition of suicide, which dates from at least the 13th century and was endorsed by some of the greatest figures in English legal history, the Ninth Circuit attributed this legal norm to "taboos" and to "the ancient fear that the spirit of someone who ended his own life would return to haunt the living." Pet. App. A46. The court then made much of the decriminalization of suicide in the last century (Pet. App. A46-A47), without pointing out that the reason for this was that punishment was deemed an inappropriate social response. See e.g., *State* v. *Marti*, 290 N.W.2d 570, 581 (Iowa 1980) ("The only reason we view suicide [as] noncriminal is that we consider inappropriate punishing the suicide victim or attempted suicide victim, not that we are concerned about that person's life any less than others' lives); *Commonwealth* v. *Mink*, 123 Mass. 422, 429 (1877) (repeal of sanctions for suicide "may well have had its origin in consideration for the feelings of innocent surviving relatives"); Testimony of Prof. Victor Rosenblum, HOUSE HEARINGS, at 283.

As noted, 46 states now prohibit assisted suicide, and many of those prohibitions are the product of recent deliberation. The Ninth Circuit gives no weight to this legislative record. Instead, the court cites public opinion polls that, according to the court, show popular support for a change in the laws. Pet. App. A48-A49. Incredibly, the court draws further support from the fact that, while voters rejected assisted suicide in referenda in California and Washington, the votes were close. The court's infatuation with polling data extends even to professional opinion, since the court relied on polls purporting to show that physicians support assisted suicide — (*id.* at A92-A93) — even though their professional organizations are formally on record as opposing it and the precepts of medical ethics forbid it.

It hardly needs be said that constitutional law should not be governed by public opinion polls. We doubt seriously that the Ninth Circuit would be greatly impressed by polls showing overwhelming support for school prayer, capital punishment, or laws against flag burning. We think it is far more significant that

every time the question of assisted suicide is subjected to *reasoned deliberation* — whether by legislature or by commission — the wisdom of the traditional prohibition is reaffirmed.

Putting aside its incursion into selective ancient history and its opportunistic invocation of opinion polls, the Ninth Circuit has literally *no support* for its conclusion that the right to assisted suicide is grounded in this nation's history or tradition.

To affirm the decision below would require an extraordinary transformation of constitutional principles. Since the decision has no basis in constitutional text, no basis in original understanding, no basis in the traditions of the nation, no basis in the protection of a discrete and insular minority, and no real basis in precedent, affirmance would stand for the bald proposition: the Constitution authorizes courts to invalidate laws simply on the basis that the judges disagree with them. These cases present an ideal opportunity for the Court to reassure this Nation that the judiciary does *not* purport to exercise such a power.

CONCLUSION

The decisions of the courts below should be reversed.

Respectfully submitted.

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In the Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF AMICUS CURIAE OF THE CATHOLIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the New York and Washington statutes prohibiting physician assistance in suicide violate either the Due Process Clause or the Equal Protection Clause of the Fourteenth Amendment.

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
INTEREST OF THE AMICUS CURIAE	1
SUMMARY OF ARGUMENT	2
ARGUMENT	4
I. STATES MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE DUE PROCESS CLAUSE BECAUSE SUCH PROHIBITIONS FURTHER SOCIETY'S UNQUALIFIED INTEREST IN LIFE	6
A. A Right to Give or Receive Assistance in Suicide Is Neither Implicit in the Concept of Ordered Liberty Nor Deeply Rooted in This Nation's History and Tradition	7
B. The State Has a Compelling Interest in Protecting, and Indeed an Obligation to Protect, the Lives of Its Citizens	13
II. STATES MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE EQUAL PROTECTION CLAUSE BECAUSE, UNLIKE FORGOING MEDICAL TREATMENT, ASSISTED SUICIDE ALWAYS INVOLVES AN INTENT TO KILL	18
CONCLUSION	26
APPENDIX A	1a
APPENDIX B	4a
APPENDIX C	6a

TABLE OF AUTHORITIES

CASES

	Page
Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983)	2a
Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984)	2a
Blackburn v. State, 23 Ohio St. 146 (1872)	4-5, 14, 7a
Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986)	2a
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TABLE OF AUTHORITIES—Continued

	Page
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Olmstead v. United States, 227 U.S. 438 (1928), *overruled by Katz v. United States*, 389 U.S. 347 (1967)	8

TABLE OF AUTHORITIES—Continued

	Page
Palko v. Connecticut, 302 U.S. 319 (1937)	8, 11
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TABLE OF AUTHORITIES—Continued

	Page
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D.C. Code Ann. § 21-2212 (1995)	4a
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TABLE OF AUTHORITIES—Continued

	Page
Fla. Stat. Ann. § 782.08 (West 1995)	6a
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Ga. Code Ann. § 31-36-2 (1995)	4a
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Iowa Code Ann. § 144B-12.2 (West 1995)	4a
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Ky. Rev. Stat. Ann. § 311.637 (Baldwin 1995)	4a
La. Rev. Stat. Ann. § 14:32.12 (West 1995)	6a
La. Rev. Stat. Ann. § 1299.58.10 (West 1995)	4a
Me. Rev. Stat. Ann. tit. 17-A, § 204 (West 1995)	6a
Me. Rev. Stat. Ann. tit. 18-A, § 5-813 (West 1995)	4a
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TABLE OF AUTHORITIES—Continued

	Page
Mont. Code Ann. § 45-5-105 (1993)	6a
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Neb. Rev. Stat. § 28-307 (1995)	6a
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TABLE OF AUTHORITIES—Continued

	Page
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	Page
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In the Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1858

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, and ROBERT M. MORGENTHAU, District Attorney of New York County,

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v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

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Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF AMICUS CURIAE OF THE CATHOLIC MEDICAL ASSOCIATION IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICUS CURIAE

The Catholic Medical Association ("CMA") is a non-profit, public service organization founded in 1932. The CMA promotes the principles of Roman Catholic medical ethics in science and in the practice of medicine. The

CMA includes more than one thousand physicians and coordinates the activities of more than 80 regional Catholic physicians' guilds in the United States and Canada.[1]

Since 1932, the CMA has published *The Linacre Quarterly*, a leading scholarly journal on biomedical ethics. The CMA's companion Linacre Institute routinely produces studies on important medical and moral issues. The CMA also serves as a resource for the medical community, holding annual conferences where scholars and health care professionals meet and interact.

The CMA, as an *amicus curiae* before this Court, seeks to contribute its professional and ethical perspective on physicians and their role in treating the terminally ill. Since its inception, the CMA has brought the practical experience and scholarly expertise of its members to bear on important societal issues. The CMA wishes to share with this Court the insights of the scholars and physicians that are its practicing members.

In addition to its own experience, the CMA hopes to inform the Court of a central theme in Catholic medical ethics, the distinction between meeting death with peace and dying at one's own hand.

For decades, Catholic religious and medical leaders have differentiated between suicide and the forgoing of life support. In rejecting such a distinction, the Second and Ninth Circuits broke from a venerable historical tradition. As a unique part of that tradition, the CMA asks the Court to consider its arguments in support of the Petitioners.

SUMMARY OF ARGUMENT

A right to give or receive assistance in suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this Nation's history and tradition. Other than the Ninth Circuit in its decision below, every court that

[1] The parties in both *Vacco* and *Glucksburg* have consented to the filing of this brief. The parties' letters of consent have been submitted to the Clerk of the Court.

has considered physician assisted suicide has concluded that there is no such right. Indeed, even the Second Circuit, which invalidated New York's prohibition of assistance in suicide on equal protection grounds, concluded that such a right "finds no cognizable basis in the Constitution's language or design."

Respondents claim that assisted suicide involves a decision concerning one's own body and that, as such, it falls within the realm of personal liberty that government may not enter. But the concept of ordered liberty under the Due Process Clause does not equate with unrestrained autonomy, and this Court has never endorsed demands to assist those who would make seemingly personal choices that diminish their own lives or the common good.

A right to assisted suicide finds no support in this Nation's history and tradition. At common law, a person who assisted another to commit suicide was guilty of murder. At the time of the Fourteenth Amendment, the vast majority of states explicitly prohibited assisted suicide. Even today, forty-five states continue to criminalize the practice. *See* Appendix C.

Weighing against any interest in assisted suicide is the State's compelling interest in protecting, indeed its obligation to protect, the lives of its citizens. Given the origins of government, and the nature of the bargain between the State and its citizens, the State has an obligation to protect life simply because of its existence. This obligation does not vary with the circumstances of particular citizens, but applies to all persons under the State's authority and protection. In rejecting society's obligation to protect the lives of all its citizens, the Ninth Circuit erred.

The Second Circuit similarly erred in concluding that New York's prohibition against assistance in suicide violates the Equal Protection Clause. Although the Constitution requires that all persons similarly situated should be treated alike, the Constitution does not require things

that are different to be treated as though they were the same. Physician assisted suicide is fundamentally different from forgoing medical treatment because, unlike forgoing medical treatment, assisted suicide always involves an intent to kill. In confusing the distinction between knowledge and intent, the courts of appeals rejected the common-sense notion that one may choose to forgo disproportionately burdensome medical treatment and at the same time retain a strong desire to live. Unlike some who choose to forgo medical treatment, however, those who engage in assisted suicide have death as their purpose. Such a distinction based on intent more than satisfies the constitutional requirement of rationality and nonarbitrariness.

ARGUMENT

The Declaration of Independence states that it is "self-evident" that all men "are endowed by their Creator with certain unalienable Rights," and that among these rights are "Life, Liberty, and the Pursuit of Happiness." It is no accident that life is listed first. The Due Process Clause in the Fifth and Fourteenth Amendments also puts life first: No person shall be deprived of "life, liberty, or property, without due process of law . . . ." The reason for this ordering is apparent. Without life, there can be no other rights. As Justice Holmes said, "[l]ife is an end in itself, and the only question as to whether it is worth living is whether you have enough of it." [2]

Societies throughout history, including our own, have recognized life and its protection as an unqualified good, indeed, as *the* good from which other societal goods derive.[3] Physicians serve society by maintaining life, by

[2] Oliver Wendell Holmes, Jr., Speech to the Bar Association of Boston (Mar. 7, 1900) *in* Collected Legal Papers 244, 248 (1920).

[3] Society's unqualified commitment to life runs throughout traditional jurisprudence. In *Blackburn v. State*, 23 Ohio St. 146, 163 (1872), for example, the Ohio Supreme Court observed that:

> [T]he life of those to whom life has become a burden—of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Accord, 4 William Blackstone, *Commentaries on the Laws of England* *189 ("The suicide is guilty of [an offense] against the King, who hath an interest in the preservation of all his subjects"). Similarly, this Court has acknowledged the constitutionality of such a fundamental choice for life:

> [W]e think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . . .

Cruzan v. Director, Missouri Dep't of Health, 497 U.S. 261, 282 (1990). *See also* Pope John Paul II, Encyclical Letter *Evangelium Vitae* ¶ 66 (March 25, 1995) (noting that life is God's gift and that suicide is a rejection of that gift); *accord*, 1 William Blackstone, *Commentaries on the Laws of England* *125 ("Life is the immediate gift of God, a right inherent by nature in every individual").

healing patients who request their help, and by promoting health, which is fundamental to the enjoyment of so many of life's virtues. Conversely, American society has always condemned physicians who stray from the healing path, who use their knowledge to harm, or who fail to fulfill their role as guardians of society's interest in life.[4]

The decisions here under review depart from the traditional, and salutary, emphasis on the protection of life. In invalidating New York and Washington State's prohibitions against assisted suicide, the Second and Ninth Circuits erred because: (1) a right to assisted suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this Nation's history and tradition; (2) permitting assisted suicide cannot be reconciled with gov-

[4] *See, e.g., United States v. Brandt (the Medical Case)*, II Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10, at 181 (1949); *see also United States v. Stanley*, 483 U.S. 669, 708 (1987) (O'Connor, J., concurring in part and dissenting in part).

ernment's obligation to protect the lives of the governed; and (3) assisted suicide differs fundamentally from forgoing medical treatment, because assisted suicide, by definition, involves an intent to kill.

I. STATES MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE DUE PROCESS CLAUSE BECAUSE SUCH PROHIBITIONS FURTHER SOCIETY'S UNQUALIFIED INTEREST IN LIFE.

This Court understandably has been "reluctant to expand the concept of substantive due process because guideposts for responsible decisionmaking in this unchartered area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). As the Court itself has explained, "[t]he Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution. . . . There should be, therefore, great resistance to expand the substantive reach of [the Due Process] Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority." *Bowers v. Hardwick*, 478 U.S. 186, 194-95 (1986).

Such concerns are no less apt in the area of physician assisted suicide, where "[b]road policy questions bearing on life and death issues are more properly addressed by representative assemblies." *See Cruzan v. Harmon*, 760 S.W.2d 408, 426 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). As Judge Kleinfeld wrote in dissent in this case, "[t]he Founding Fathers did not establish the United States as a democratic republic so that elected officials would decide trivia, while all the great questions would be decided by the judiciary." Glucksberg App. at 161-62.

Because of the potentially boundless nature of substantive due process claims, this Court, in reviewing such

claims, has stressed the importance of carefully describing the asserted right and the legal issue that the Court is being asked to decide. *See, e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 847-48 (1992); *Michael H. v. Gerald D.*, 491 U.S. 110, 118-30 (1989). In the Court's words, " '[s]ubstantive due process' analysis must begin with a careful description of the asserted right, for '[t]he doctrine of judicial self-restraint requires us to exercise the utmost care whenever we are asked to break new ground in this field.' " *Reno v. Flores*, 507 U.S. 292, 302 (1993) (citations omitted). Interests for which constitutional protection is sought "cannot be described merely at the level of philosophic abstraction . . . ." Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still A Wonderful Life?*, 70 Notre Dame L. Rev. 519, 559 (1995). It is critical to determine precisely what right is being asserted when statutes like those at issue here are said to violate the Due Process Clause. It is also important to inquire whether any other due process interests would be implicated if this Court were to recognize the claimed physician's right to assist in suicide.

A. A Right to Give or Receive Assistance in Suicide Is Neither Implicit in the Concept of Ordered Liberty, Nor Deeply Rooted in This Nation's History and Tradition.

Respondents assert a right, under certain circumstances, intentionally to terminate the life of a human being—a human being that the law regards as innocent of any offense. This case does not involve society's imposition of death as a sanction for some heinous wrong. Rather, it involves an alleged constitutional right to intervene to introduce a new causative factor, one which, in the absence of the intervention, would play no role in bringing about the patient's death. The Ninth Circuit failed to appreciate the significance, for constitutional purposes, of such intentional causation of death through the deliberate introduction of a poisonous drug or other lethal substance. The

court focused incorrectly on the end—death—rather than on the means by which that death occurs. In the court's words, "it is the end and not the means that defines the liberty interest."[5] By concentrating on the abstract "right to die," the court obscured meaningful practical and constitutional distinctions:

> [W]e see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. . . . *To us, what matters is that the death is the intended result as surely in one case as in the other.*

Glucksberg App. at 82 (emphasis supplied).

This Court, however, historically has afforded protection only to those interests "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937), *quoted in Bowers v. Hardwick*, 478 U.S. 186, 191-92 (1986). In an alternative formulation, this Court has described those interests entitled to constitutional protection as ones "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977).

Other than the Ninth Circuit in the decision below, every court that has considered physician assisted suicide has concluded that "the right to commit suicide is neither implicit in the concept of ordered liberty nor deeply rooted in this nation's history and tradition. It would be an impermissibly radical departure from existing tradition, and

[5] Glucksberg App. at 27. In response to similar arguments nearly seventy years ago, Justice Brandeis issued his famous warning:

> To declare that in the administration of the criminal law the end justifies the means . . . would bring terrible retribution. Against that pernicious doctrine this Court should resolutely set its face.

Olmstead v. United States, 277 U.S. 438, 468 (1928) (Brandeis, J., dissenting), *overruled by Katz v. United States*, 389 U.S. 347 (1967).

from the principles that underlie that tradition, to declare that there is such a fundamental right protected by the Due Process Clause." *See, e.g., People v. Kevorkian*, 447 Mich. 436, 481, 527 N.W.2d 714, 732 (1994), *cert. denied*, 115 S. Ct. 1795 (1995). Even the Second Circuit, which invalidated on equal protection grounds New York's prohibition against assistance in suicide, concluded that "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those competent persons who, in the final stages of terminal illness, seek the right to hasten death." Vacco App. at 19a.[6]

The concept of ordered liberty under the Due Process Clause does not equate with unrestrained autonomy. For example, this Court has never held that the Constitution confers an absolute right to do as one pleases with one's own body. *See, e.g., Roe v. Wade*, 410 U.S. 113, 154 (1973) (refusing to recognize such a right). Thus, a person has a right to refuse medical treatment, but no right to refuse vaccination from contagious disease. *See Washington v. Harper*, 494 U.S. 210, 222 (1990); *Jacobson v. Massachusetts*, 197 U.S. 11, 26-27 (1905) (rejecting autonomy right in favor of the common good). A person has a right to marry, but no right to marry his or her blood relatives. A person has a right to direct the upbringing of his or her children, but no right to expose them to deadly harm. *See Prince v. Massachusetts*, 321 U.S. 158, 166 (1944). "The statute books are replete with constitutionally unchallenged laws against prostitution, suicide, voluntary self-mutilation, brutalizing 'bare fist' prize fights, and duels, although these crimes may only directly involve 'consenting adults.'" *Paris Adult*

[6] Courts from other common law jurisdictions have reached similar conclusions. The Supreme Court of Canada, for example, has rejected a claim that Section 7 of the Canadian Charter of Rights and Freedoms, similar in scope to the Due Process Clause, establishes a fundamental right to physician assisted suicide. *See generally Rodriguez v. British Columbia (Attorney General)*, 3 S.C.R. 519 (Can. 1993).

Theatre I v. Slaton, 413 U.S. 49, 68 n.15 (1973). In each of these instances, claims for individual autonomy must be balanced against, and sometimes subordinated to, the common good. Indeed, the law has always acted to restrain choice that harms individual persons. Because we are a society that "strongly affirms the sanctity of life," [7] this Court has never endorsed demands to assist those who would make seemingly personal choices that diminish their own lives or the common good.

Respondents, however, maintain that "there is a realm of personal liberty which the government may not enter." Glucksberg et al., Opposition to Petition for Writ of Certiorari at 12. They further argue that this Court's precedent in the area of reproductive choice "acknowledge[s] that *decisions concerning one's own body*, one's own medical care, and one's own future life course fall within that realm." *Id.* (emphasis supplied). Yet, this Court has routinely rejected such an expansive view of personal autonomy, holding that there is no "*unlimited right to do with one's body as one pleases.*" *Roe*, 410 U.S. at 154 (emphasis supplied); *see also Bowers*, 478 U.S. at 191; *Slaton*, 413 U.S. at 68.

A due process right to physician assisted suicide also remains unsupported by this nation's history and tradition. "At common law suicide was a felony, punished by forfeiture of property to the king and ignominious burial. . . . Essentially, suicide was considered a form of murder." *In re Joseph G.*, 34 Cal. 3d 429, 433, 194 Cal. Rptr. 163, 165 (1983) (citations omitted). In the United States, most jurisdictions today regard suicide as "an expression of mental illness" or depression.[8] *Id.* Further, at common law, a person who assisted another to commit suicide was guilty of murder. *In re Joseph G.*, 34 Cal. 3d at 434, 194 Cal. Rptr. at 165. Perhaps most telling is the fact that "[a]t the time the Fourteenth Amendment was ratified, at least twenty-one of the thirty-seven existing states (including eighteen of the thirty ratifying states) proscribed assisted suicide either by statute or as a common-law offense." *Kevorkian*, 447 Mich. at 478, 527 N.W.2d at 731. Indeed, in *Cruzan*, Justice Scalia concluded that " 'there is no significant support for the claim that a right to suicide is so rooted in our tradition that it may be deemed 'fundamental' or 'implicit in the concept of ordered liberty.' ' " *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring) (citations omitted). Of course, if there is no liberty interest to commit suicide, there can be no liberty interest in receiving the assistance of another to do so. *Kevorkian*, 447 Mich. at 468 n.35, 527 N.W.2d at 726 n.35.

Respondents and the Ninth Circuit attempt to avoid this historical consensus in two ways. First, they question the continued vitality of this Court's reasoning in *Palko v. Connecticut* and *Moore v. East Cleveland*. *See, e.g.*, Glucksberg App. at 55 (suggesting that *Palko's* actual language results in too strict a test); Glucksberg et al., Brief of Appellees in the Ninth Circuit at 27 n.29 (arguing that, instead of *Palko*'s ordered liberty test, the Ninth Circuit should look to the "conscience of the people").

Instead of looking to *Palko* and *Moore*, respondents extract certain language from this Court's decision in *Casey* to formulate a new general test for evaluating rights under the Due Process Clause. In *Casey*, the Court stated that "[t]hese matters, involving the most intimate

[7] *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan, J., concurring).

[8] The medical literature amply supports such conclusions. "Studies that examine the psychological background of individuals who kill themselves show that 95 percent have a diagnosable mental disorder at the time of death." New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* 11 (May 1994). Further, "[l]ike other suicidal individuals, patients who desire suicide or an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly depression." *Id.* at 13.

and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S. at 851. On the basis of this language, respondents identify any issue potentially important to personal dignity as a liberty interest, and then inquire whether, under a balancing test, that interest has been burdened by state action. *See, e.g.*, Glucksberg App. at 54-62.

Respondents' approach reads far too much into a single excerpt from the opinion in *Casey* and ignores the context in which that statement was made. *Casey* did not purport to engage in a fresh due process inquiry; indeed, as the plurality opinion demonstrates, a woman's right to choose an abortion was explicitly retained based on the settled expectations of *stare decisis*. *Casey*, 505 U.S. at 871. *Casey*, therefore, is an inappropriate tool to use as a lever to expand the limits of this Court's previously settled due process jurisprudence. Moreover, this Court's abortion cases in general, and the *Casey* opinion in particular, should not be used to draw general conclusions about the Due Process Clause outside the abortion context. Instead, as the Court has observed, "[a]bortion is a *unique* act. [In abortion,] . . . the liberty of the woman is at stake in a sense unique to the human condition and so *unique* to the law." *Id.* at 852 (emphasis supplied).

The Ninth Circuit's opinion below also attempts to avoid the historical consensus on assisted suicide by augmenting history. Although acknowledging society's historic opposition to assisted suicide, the Ninth Circuit refers to a supposedly "strong undercurrent of a time-honored but hidden practice" of assisted suicide that runs "beneath the official history of legal condemnation of physician-assisted suicide." Glucksberg App. at 51. This approach, however, fundamentally misapplies the reasoning of *Moore v. East Cleveland*, by giving preference to

an esoteric historical account over innumerable public acts rejecting the practice of assisted suicide.[9]

B. The State Has a Compelling Interest in Protecting, and Indeed an Obligation to Protect, the Lives of Its Citizens.

Even if this Court were to recognize some protected interest in giving or receiving assistance in suicide, that would not end the matter. The Court would need also to consider a State's compelling interest in protecting—indeed, the State's obligation to protect—the lives of its citizens.

As John Locke wrote, the "great and chief end" of those who "seek out and [are] willing to join in society" is "the *mutual* preservation of their lives." John Locke, *Two Treatises on Government* 350 (Peter Laslett ed. 1988) (emphasis supplied).[10] For Locke, and for the Framers of our Constitution, human beings come together in free society, consent to be governed, and, in return, receive a covenant from government that each citizen's life will be protected equally and unqualifiedly before the law. *Id.* As this Court has held, that covenant applies broadly to:

> all the powers of government, legislative as well as executive and judicial. It necessarily happened, therefore, that as these broad and general maxims of liberty and justice held in our system a different place and performed a different function from their position and office in English constitutional history and law, they would receive and justify a corresponding and more comprehensive interpretation. Applied in England only as guards against executive usurpation and

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[9] Perhaps mindful of the implausibility of its own historical account, the Ninth Circuit also refers to what it terms "drastic changes" in the public's recent attitudes toward physician assisted suicide. Glucksberg App. at 77.

[10] Locke was a staunch opponent of suicide, regarding it as the duty of each citizen "not to quit [one's] station willfully." John Locke, *Two Treatises on Government* 271 (Peter Laslett ed. 1988).

> tyranny, here they . . . must be held to guaranty not particular forms of procedure, but the very substance of individual rights to life, liberty, and property.

Hurtado v. California, 110 U.S. 516, 531 (1884).

Given the origins of government, and the nature of the bargain between the State and its citizens, the State has an obligation to protect life simply because of its existence, apart from any other consideration. This obligation does not vary with the circumstances of particular citizens but applies to all persons under the State's authority. As the Ohio Supreme Court wrote not long after the adoption of the Fourteenth Amendment:

> The life of those to whom life has become a burden —of those who are hopelessly diseased or fatally wounded—nay, even the lives of criminals condemned to death, are under the protection of the law, equally as the lives of those who are in the full tide of life's enjoyment, and anxious to continue to live.

Blackburn v. State, 23 Ohio St. 146, 163 (1872); *accord*, *Cruzan*, 497 U.S. at 295 (Scalia, J., concurring).[11]

Both history and tradition support the State's obligation to protect life and the citizen's right to expect such protection. Ever since the founding of the Republic, we have been a nation that "strongly affirms the sanctity of life." *Furman v. Georgia*, 408 U.S. 238, 286 (1972) (Brennan,

[11] This principle runs throughout Catholic medical ethics as well. Indeed, the Catholic Church has always taught that "[t]he inviolability of human life means and implies in the last analysis the illicitness of every act which directly suppresses human life. 'The inviolability of the right to life of the innocent human being from conception to death is a sign and a requirement of the very inviolability of the person, to whom the Creator has given the gift of life.'" Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶ 136 (Boston: Daughters of St. Paul 1995), *quoting* Sacred Congregation for the Doctrine of the Faith, Instruction *Donum Vitae*, *in* 80 Actus Apostolicae Sedes 75-76 (1988).

J., concurring). "As a general matter, the States—indeed, all civilized nations—demonstrate their commitment to life by treating homicide as a serious crime. Moreover, the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." *Cruzan*, 497 U.S. at 280. As the British House of Lords recently concluded, this fundamental proposition is shared by all common law countries and is expressed in:

> society's prohibition of intentional killing. *That prohibition is the cornerstone of law and of social relationships. It protects each one of us impartially, embodying the belief that all [lives] are equal.*

Select Committee on Medical Ethics of the House of Lords, *Report of the Select Committee on Medical Ethics* 48 (Jan. 1994) (emphasis supplied).[12]

Physician assisted suicide always involves the taking of human life, and, as such, permitting it would run counter to the State's fundamental obligation to protect its citizens. To be sure, physician assisted suicide advocates, including respondents, seek to limit the practice to certain narrowly defined circumstances, such as where a person is both terminally ill and mentally competent.[13] *See, e.g.*, Glucksberg App. at 9-11. All such proposed limitations, how-

[12] The House of Lords went on to apply this "cornerstone of law" to physician assisted suicide and euthanasia. It concluded that, "[w]e do not wish that protection to be diminished and we therefore recommend that there should be no change in the law to permit euthanasia." Select Committee on Medical Ethics of the House of Lords, *Report of the Select Committee on Medical Ethics* 48 (Jan. 1994).

[13] If this Court were to find a right to physician assisted suicide, it is by no means certain that such a right could be limited to the terminally ill. At least one lower court has held that any such limitation would violate the Equal Protection Clause. *See generally Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), *appeal docketed*, Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949 (9th Cir. Aug. 7, 1995).

ever, necessarily rest on a judgment about quality of life. Such judgments are foreign to this Court's jurisprudence.

In *Cruzan*, this Court held that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life . . . ." *Cruzan*, 497 U.S. at 282. Indeed, the risk in making such decisions about quality of life is great. As the Missouri Supreme Court noted in *Cruzan*, "[w]ere quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives." *Cruzan v. Harmon*, 760 S.W.2d 408, 420 (Mo. 1988) (en banc), *aff'd sub nom. Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). Not surprisingly, the disabled count themselves among the strongest opponents of physician assisted suicide, which they regard as "based on erroneous judgments concerning the quality of life of a person with a disability or on social judgments that such a person's continued existence will impose an 'unacceptable' burden on his or her family or on the Nation as a whole. These judgments are often grounded in misinformation, inaccurate stereotypes, and negative attitudes about people with disabilities." United States Commission on Civil Rights, *Medical Discrimination Against Children with Disabilities* 12 (1989).

This Court itself has previously declined to differentiate among the due process rights of individuals based on their quality of life. In *United States v. Rutherford*,[14] terminal cancer patients sued to overturn the FDA's decision that Laetrile was not "safe and effective" within the meaning of the Food, Drug, and Cosmetic Act.[15] They sought, in effect, to substitute their judgment for that of the medical community about what might improve their quality of life.

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[14] 442 U.S. 544 (1979).

[15] 21 U.S.C. §§ 201, 355 (1996).

The terminally ill plaintiffs in *Rutherford* convinced a lower court that they had a due process right to choose even potentially unsafe and ineffective drugs because of their diminished quality of life.[16] Plaintiffs argued that the definition of safe and effective medical care had to be modified because their lives, which were of presumably limited duration, were entitled to a lesser degree of governmental protection.[17] This Court refused to recognize any dilution of due process based on quality of life. *Rutherford*, 442 U.S. at 555, 559. Although *Rutherford* ultimately was resolved on statutory grounds, it illustrates the caution with which courts should approach arguments based on diminished quality of life. *Id.*

Even if the Court were inclined to recognize some protected interest in suicide or assisted suicide, therefore, it should also recognize a fundamental obligation on the part of the State to protect the lives of its citizens. Allowing physician assisted suicide is incompatible with that obligation. As one medical organization recently observed, physician assisted suicide involves:

> *the deliberate taking of human life* [*and*] *should remain a crime.* This [Association's] rejection of a change in the law to permit doctors to intervene to end a person's life is not just a subordination of individual well-being to social policy. *It is instead an affirmation of the supreme value of the individual, no matter how worthless and hopeless that individual may feel.*

British Medical Association, *Euthanasia: Report of the Working Party to Review the British Medical Association's Guidance on Euthanasia* 69 (1988).[18]

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[16] *Rutherford v. United States*, 438 F. Supp. 1287, 1298-1301 (W.D. Okla. 1977).

[17] *Rutherford*, 442 U.S. at 551.

[18] Confirming the existence of a fundamental governmental obligation to protect the lives of its citizens would *not* require this Court

II. STATES MAY PROHIBIT ASSISTED SUICIDE CONSISTENT WITH THE EQUAL PROTECTION CLAUSE BECAUSE, UNLIKE FORGOING MEDICAL TREATMENT, ASSISTED SUICIDE ALWAYS INVOLVES AN INTENT TO KILL.

Although the Equal Protection Clause requires that "all persons similarly circumstanced should be treated alike, . . . [t]he Constitution does not require things which are different in fact or opinion to be treated in law as though they were the same." *Plyler v. Doe*, 457 U.S. 202, 216 (1982) (internal quotations and citations omitted). Instead, disparate treatment normally will pass equal protection scrutiny if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985).

The Second Circuit invalidated New York's prohibition against physician assisted suicide, reasoning that a state may not allow a terminally ill patient to hasten his or her death by forgoing life support and, at the same time, prevent a physician from dispensing lethal drugs to a terminally ill patient who wishes to use them to commit suicide. Vacco App. at 29a-30a. The Second Circuit based its holding on the premise that forgoing medical treatment and assisted suicide are indistinguishable. Vacco App. at 30a-31a. The Second Circuit failed to recognize, however, that physician assisted suicide always involves an intent to terminate a life, while forgoing medical treatment does not. The court also disregarded legitimate state interests supporting New York's prohibition of physician assisted suicide.

to reexamine any of its prior decisions. A person can forfeit either liberty or life through wrongdoing or malfeasance. That fact does not diminish the importance of those rights any more than the fact that there are inmates in our prisons calls into question the inalienability of the rights Jefferson declared.

Nor is there any inconsistency with this Court's decisions in *Casey* and earlier cases dealing with abortion. This Court has held that abortion does not extinguish the life of a "person" for purposes of the Fourteenth Amendment. *Roe*, 410 U.S. at 153 ("The word 'person,' as used in the Fourteenth Amendment, does not include the unborn"). Even so, it is well-settled that the States at least have "legitimate interests from the outset of the pregnancy in protecting . . . the life of the fetus that may become a child." *Casey*, 505 U.S. at 846.

The moral, civil, and common law has always regarded the refusal or withdrawal of medical treatment as fundamentally different from suicide.[19] There is, moreover, an obvious common-sense basis for this distinction. According to the American Bar Association, decisions to refuse treatment are "legally and ethically distinct" from decisions to administer "a lethal agent with the intentional purpose of terminating life." American Bar Association, Commission on Legal Problems of the Elderly, Memorandum of Jan. 17, 1992, *reprinted in* 8 Issues L. & Med. 117, 118 (1992). Assisted suicide "involves not letting the patient die, but making the patient die . . . ." Stephen L. Carter, *The Culture of Disbelief: How American Law and Politics Trivialize Religious Devotion* 236 (1993).

The difference between forgoing medical treatment and assisted suicide centers on the *mens rea* necessarily involved. According to one commentator:

> The definition of *suicide requires that one's actions be carried out for the purpose of bringing about death either as an end or as a means.* The soldier who throws himself on the live grenade to save his companions, for example, is not aiming at death. That is, he does not intentionally jump on the grenade for the purpose of bringing about his death, but rather for the purpose of saving his companions. This is clear if one considers that, if he lives and his companions are saved, then he would have achieved his purpose without dying. For this reason, his act is

[19] *See* Yale Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735, 753-60 (1995); Thomas J. Marzen et al., *Suicide: A Constitutional Right?* 24 Duq. L. Rev. 1, 9-13 (1985).

> not counted as suicide. On the other hand, consider the man who kills himself so his family can enjoy the proceeds from his life insurance. Clearly, he intentionally carries out his actions for the purpose of bringing about death. He is aiming at his death, albeit as a means to another end: if he lives, he would have failed in his purpose since, without his death, no inheritance will be forthcoming.

Manual G. Velasquez, *Defining Suicide*, 3 Issues L. & Med. 37, 49 (1987) (emphasis supplied). Assisted suicide, therefore, necessarily involves an intent to kill. Patients, on the other hand, can forgo medical treatment without such an intent. Indeed, they may act:

> in order to safeguard themselves at the point of death against "the use of techniques that run the risk of becoming abusive." Contemporary Medicine in fact, has at its disposal methods which artificially delay death, without any real benefit to the patient. It is merely keeping one alive or prolonging life for a time, at the cost of further, severe suffering. This is so-called "therapeutic obstinacy," which consists "of the use of methods which are particularly exhausting and painful for patients, condemning them, in fact, to an artificially prolonged agony."

Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶ 119 (Boston: Daughters of St. Paul 1995), *quoting* Pope John Paul II, *Address to the Participants at the International Congress on Assistance to the Dying, in* OssRom, Mar. 18, 1992. at 65 n.4; and Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 549 (Boston: Daughters of St. Paul 1980). In such circumstances:

> For doctors and their assistants it is not a question of deciding the life or death of an individual. It is simply a question of being a doctor, that is of posing the question and then deciding according to one's expertise and one's conscience regarding a respectful care of the living and the dying of the patient en-

> trusted to one. This responsibility does not always and in all cases involve recourse to every means [of treatment]. It might also require the renunciation of certain means to make way for a serene and Christian acceptance of death, which is inherent in life. It might also mean respect for the wishes of the patient who refuses the use of such means.

Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶ 121 (Boston: Daughters of St. Paul 1995). Properly understood, forgoing treatment occurs with neither the patient nor the physician desiring that death occur. Neither intends to cause or hasten it. Instead, the inquiry focuses on whether the medical treatment in question is effective, overly burdensome, and requires heroic virtue to endure. If so, the patient may choose to forgo the treatment as an end in itself. *Id.* The fact that death may result is merely a foreseen but unintended side effect. *Id.*

Medical science can offer numerous examples in which the decision to forgo medical treatment does not involve an intent to kill or to die. For example, a feeding tube can become hopelessly burdensome. The tube can cause significant pain, it can result in serious infection, and it can fail to transmit nourishment effectively. Under such circumstances, the patient might well choose to forgo the feeding tube as disproportionately burdensome. The patient could make such a choice, however, while at the same time hoping that he or she could be effectively fed intravenously and praying that the underlying pathology would abate. The fact that intravenous feeding may turn out ultimately to be ineffective and that the patient ultimately may die as a result does not change the analysis.

The Second and Ninth Circuits, in rejecting any distinction between assisted suicide and forgoing medical treatment, seem to confuse purpose or intent with knowledge. Vacco App. at 30a-31a; Glucksberg App. at 78-82. As the Ninth Circuit held:

> [W]e see little, if any, difference for constitutional . . . purposes between providing medication with a double effect and providing medication with a single effect, as long as one of the *known* effects in each case is to hasten the end of the patient's life. Similarly, we see no ethical or constitutionally cognizable difference between a doctor's pulling the plug on a respirator and his prescribing drugs which will permit a terminally ill patient to end his own life. In fact, some might argue that pulling the plug is a more culpable and aggressive act on the doctor's part and provides more reason for criminal prosecution. *To us, what matters most is that the death of the patient is the intended result as surely in one case as in the other.*

Glucksberg App. at 82 (emphasis supplied).

This Court previously has highlighted the distinction between purpose and knowledge. In *United States v. Bailey*,[20] for example, the Court recognized that "[f]ew areas of criminal law pose more difficulty than the proper definition of the *mens rea* required for any particular crime."[21] *Bailey* established a "hierarchy of culpable states of mind" and distinguished among "purpose, knowledge, recklessness, and negligence."[22] In doing so, it explained that "[p]erhaps the most significant and most esoteric, distinction drawn by this analysis is that between the mental states of 'purpose' and 'knowledge.'"[23] The distinction becomes particularly important:

> [i]n certain narrow classes of crimes [where] . . . heightened culpability has been thought to merit special attention. Thus, the statutory and common law of homicide often distinguishes, either in setting

[20] 444 U.S. 394 (1980).

[21] *Id.* at 403.

[22] *Id.* at 404.

[23] *Id.*

> the "degree" of the crime or in imposing punishment, between a person who knows that another person will be killed as the result of his conduct and a person who acts with the specific purpose of taking another's life.[24]

As a definitional matter, this Court held that:

> [A] person who causes a particular result is said to act purposely if "he consciously desires that result, whatever the likelihood of that result happening from his conduct," while he is said to act knowingly if he is aware "that the result is practically certain to follow from his conduct, whatever his desire may be as to that result."[25]

This Court's recognition of the distinction between purpose, on the one hand, and a foreseen but unintended side effect, on the other, is perhaps most clearly set out in *Personnel Adm'r of Mass. v. Feeney*.[26] There, the Court relied on the distinction (sometimes referred to as the "principle of double effect") in addressing a claim that Massachusetts had discriminated impermissibly on the basis of gender by giving hiring preferences to military veterans, most of whom were men. *Feeney*, 442 U.S. at 259. The Court observed:

> The appellee's ultimate argument rests upon the presumption, common to the criminal and civil law, that a person intends the natural and foreseeable consequences of his voluntary actions. . . . [Culpable] purpose, however, implies more than intent as volition or intent as awareness of consequences. It implies that the decisionmaker, in this case a state legislature, selected or reaffirmed a particular course of action at least in part "because of," not merely "in spite of," its adverse effects . . . .

Id. at 278-79.

[24] *Id.* at 405.

[25] *Id.* at 404 (citation omitted).

[26] 442 U.S. 256 (1979).

Respondents may argue that, apart from any distinction between assisted suicide and forgoing medical treatment, many people actually forgo medical treatment with the intent of hastening death. That, unfortunately, may be so, but it does not lessen in any way the validity of the distinction for those who forgo treatment without an intent to kill. Nor does it disable the State from relying on the distinction in determining which conduct should be proscribed.

The fact that statutes in all fifty states distinguish between forgoing certain medical treatment and physician assisted suicide confirms both the reasonableness and the widespread nature of the distinction. Appendix B lists the numerous state living will statutes that expressly permit forgoing life support but at the same time reject physician assisted suicide. Appendix A lists the many state court decisions that adopt the same distinction. Appendix C lists the state statutes and judicial decisions that criminalize assisting a suicide but say nothing about forgoing medical treatment. All of this authority supports the proposition that a person's intent is central in determining the proper legal characterization of acts or omissions. As Justice Scalia wrote in *Cruzan*:

> Starving oneself to death is no different from putting a gun to one's own temple as far as the common law definition of suicide is concerned [because both involve] "the suicide's *conscious decision* to [put] an end to his own existence."

Cruzan, 497 U.S. at 296-97 (Scalia, J., concurring) (emphasis supplied and citations omitted).

Respondents also may argue that physicians at times cause death by employing measures deliberately chosen for the treatment of pain. Indeed, both the Second and Ninth Circuit explicitly mention such allegations in their opinions below. Vacco App. at 30a-31a; Glucksberg App. at 79. Once again, the physician's purpose, the result the physician intends to produce, provides a principled basis

on which to distinguish between assisted suicide and palliative care. As one medical text observes:

> Human and Christian prudence suggests the use for most patients of medicines which alleviate or suppress pain, even if this causes torpor or reduced lucidity. . . . When "proportionate means" so require, "it is permitted to use with moderation narcotics which alleviate suffering, but which also hasten death." In this case, "death is not intended or sought in any way, although there is a risk of it for a reasonable cause: what is intended is simply the alleviation of pain in an effective way, using for that purpose those painkillers available to medicine."

Pontifical Council for Pastoral Assistance to Health Care Workers, *Charter for Health Care Workers* ¶¶ 122-23 (Boston: Daughters of St. Paul 1995), *quoting* Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* 548 (Boston: Daughters of St. Paul 1980). Further, the opinions below vastly underrate both medical science's capacity to treat pain effectively and its ability to avoid any unintended lethal side effects of palliative care. *See, e.g.*, Michael H. Levy, *Drug Therapy: Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1124-32 (1996) (noting that the appropriate use of pain medications, particularly in combination, "rarely results in respiratory depression or cardiovascular collapse").

In order for the New York and Washington State statutory schemes to survive equal protection scrutiny, they need only a rational basis. *Cleburne Living Ctr.*, 473 U.S. at 440. The fact that a statute may have other effects or be unwise as a matter of public policy will not suffice. *Id.* Only if such legislation is irrational will the Court invalidate it. *Kadrmas v. Dickinson Pub. Sch.*, 487 U.S. 450, 462 (1988) ("Social and economic legislation . . . carries with it a presumption of rationality that can only be overcome by a clear showing of arbitrariness and irrationality."). Indeed, in discussing such rational basis scrutiny, this Court has stated that:

> the Fourteenth Amendment permits the States a wide scope of discretion in enacting laws which affect some groups of citizens differently than others. The constitutional safeguard is offended only if the classification rests on grounds wholly irrelevant to the achievement of the State's objective. State legislatures are presumed to have acted within their constitutional power despite the fact that, in practice, their laws result in some inequality. A statutory discrimination will not be set aside if any state of facts reasonably may be conceived to justify it.

McGowan v. Maryland, 366 U.S. 420, 425-26 (1961). Given the intent-based distinction between assisted suicide and forgoing medical treatment, the New York and Washington State statutory schemes more than satisfy the constitutional requirement of rationality and non-arbitrariness.

CONCLUSION

The judgments of the courts of appeals should be reversed.

Respectfully submitted,

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APPENDICES

APPENDIX A

The state courts of last resort that have distinguished between forgoing life support and assisted suicide include:

Rasmussen v. Fleming, 154 Ariz. 207, 218, 741 P.2d 674, 685 (1987)

Thor v. Superior Court, 5 Cal. 4th 725, 742, 855 P.2d 375, 385, 21 Cal. Rptr. 2d 357, 367 (1993)

McConnell v. Beverly Enters., 209 Conn. 692, 710, 553 A.2d 596, 605 (1989)

In re Browning, 568 So. 2d 4, 14 (Fla. 1990)

State v. McAfee, 259 Ga. 579, 580, 385 S.E.2d 651, 652 (1989)

In re Estate of Longeway, 133 Ill. 2d 33, 41, 549 N.E.2d 292, 296 (1989)

In re Lawrance, 579 N.E.2d 32, 40 n.4 (Ind. 1991)

DeGrella ex rel. Parrent v. Elston, 858 S.W.2d 698, 707 (Ky. 1993)

In re P.V.W., 424 So. 2d 1015, 1022 (La. 1982)

In re Gardner, 534 A.2d 947, 955-56 (Me. 1987)

In re Doe, 411 Mass. 512, 522, 583 N.E.2d 1263, 1270, *cert. denied*, 503 U.S. 950 (1992)

Brophy v. New England Sinai Hosp., 398 Mass. 417, 439, 497 N.E.2d 626, 638 (1986).

Superintendent of Belchertown v. Saikewicz, 373 Mass. 728, 744 n.11, 370 N.E.2d 417, 426 n.11 (1961)

People v. Kevorkian, 447 Mich. 436, 472-73, 527 N.W.2d 714, 728-29 (1994), *cert. denied*, 115 S. Ct. 1795 (1995)

McKay v. Bergstedt, 106 Nev. 808, 823, 801 P.2d 617, 627 (1990)

In re Farrell, 108 N.J. 335, 350, 529 A.2d 404, 411 (1987)

In re Conroy, 98 N.J. 321, 350-51, 486 A.2d 1209, 1224 (1985)

In re Quinlan, 70 N.J. 10, 51-52 & n.9, 355 A.2d 647, 669-70 & n.9, *cert. denied*, 429 U.S. 922 (1976)
Fosmire v. Nicoleau, 75 N.Y.2d 218, 227 n.2, 551 N.E.2d 77, 82 n.2, 551 N.Y.S.2d 876, 881 n.2 (1990)
In re Storar, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 358 (1981)
In re Fiori, 673 A.2d 905, 910 (Pa. 1996)
In re Grant, 109 Wash. 2d 545, 563-64, 747 P.2d 445, 454-55 (1987), *modified on other grounds*, 757 P.2d 534 (Wash. 1988)
In re L.W., 167 Wis. 2d 53, 83, 482 N.W.2d 60, 71 (1992)

A number of state lower courts have also distinguished between forgoing life support and assisted suicide, including:

Donaldson v. Lundgren, 2 Cal. App. 4th 1614, 1621, 4 Cal. Rptr. 2d 59, 62 (1992)
People v. Adams, 216 Cal. App. 3d 1431, 1440, 265 Cal. Rtpr. 568, 573-74 (1990)
Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1144-45, 225 Cal. Rptr. 297, 306 (1986)
Bartling v. Superior Court, 163 Cal. App. 3d 186, 196, 209 Cal. Rptr. 220, 225 (1984)
Barber v. Superior Court, 147 Cal. App. 3d 1006, 1012, 195 Cal. Rptr. 484, 487 (1983)
Foody v. Manchester Mem. Hosp., 40 Conn. Supp. 127, 137, 482 A.2d 713, 720 (Super. Ct. 1984)
In re Severns, 425 A.2d 156, 158 (Del. Ch. 1980)
Satz v. Perlmutter, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980)
In re Rosebush, 195 Mich. App. 675, 681 n.2, 491 N.W.2d 633, 636 n.2 (1992)
Von Holden v. Chapman, 87 A.D.2d 66, 70, 450 N.Y.S.2d 623, 627 (App. Div. 1982)

In re Eichner, 102 Misc. 2d 184, 205, 423 N.Y.S.2d 580, 594 (Sup. Ct. 1979), *aff'd as modified sub nom. Eichner v. Dillon*, 73 A.D.2d 431, 426 N.Y.S. 2d 517 (App. Div. 1980), *aff'd as modified sub nom. In re Storar*, 52 N.Y.S.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981)
Leach v. Akron Gen. Med. Ctr., 68 Ohio Misc. 1, 10, 426 N.E.2d 809, 815 (Ct. C.P. 1980)
In re Fiori, 438 Pa. Super. 610, 619, 652 A.2d 1350, 1354 (1995) (en banc), *aff'd*, 673 A.2d 905 (Pa. 1996)

APPENDIX B

The state living will statutes that distinguish between forgoing life support and assisted suicide include the following:

Ala. Code § 22-8A-10 (1995)
Alaska Stat. § 18.12.080(f) (1995)
Ariz. Rev. Stat. Ann. § 36-3210 (1995)
Ark. Code Ann. § 20-17-210(g) (Michie 1995)
Cal. Health & Safety Code § 7191.5(g) (West 1995)
Colo. Rev. Stat. Ann. § 15-18-112(1) (West 1995)
Conn. Gen. Stat. Ann. § 19a-575 (West 1995)
Del. Code Ann. tit. 16, § 2507 (1995)
D.C. Code Ann. § 6-2430 (1995)
D.C. Code Ann. § 21-2212 (1995) (durable power of attorney for health care)
Fla. Stat. Ann. § 765.309(1) (West 1995)
Ga. Code Ann. § 31-32-9 (1995)
Ga. Code Ann. § 31-36-2 (1995) (durable power of attorney for health care)
Haw. Rev. Stat. § 327D-13 (1995)
Idaho Code § 39-161(1) (1995) (do not resuscitate orders)
Ill. Comp. Stat. ch. 755, para. 35/9(f) (Smith-Hurd 1995)
Ill. Comp. Stat. ch. 755, para. 40/50 (Smith-Hurd 1995) (durable power of attorney for health care)
Ind. Code Ann. § 16-36-1-13 (West 1995) (durable power of attorney for health care)
Ind. Code Ann. § 16-36-4-19 (West 1995)
Iowa Code Ann. § 144A.11.6 (West 1995)
Iowa Code Ann. § 144B.12.2 (West 1995) (durable power of attorney for health care)
Kan. Stat. Ann. § 65-28,109 (1995)
Ky. Rev. Stat. Ann. § 311.637 (Baldwin 1995)
La. Rev. Stat. Ann. § 1299.58.10 (West 1995)
Me. Rev. Stat. Ann. tit. 18-A, § 5-813 (West 1995)
Md. Code Ann., Health-Gen. § 5-611 (1995)
Mass. Gen. Laws Ann. ch. 201D, § 12 (West 1995) (durable power of attorney for health care)

Mich. Comp. Laws Ann. § 700.496(20) (West 1995) (durable power of attorney for health care)
Minn. Stat. Ann. § 145B.14 (West 1995)
Miss. Code Ann. § 41-41-117(2) (1993)
Mo. Ann. Stat. § 459.055(5) (Vernon 1995)
Mont. Code Ann. § 50-9-205(7) (1995)
Neb. Rev. Stat. § 20-412(7) (1995)
Nev. Rev. Stat. § 449.670(2) (1993)
N.H. Rev. Stat. Ann. § 137-H:10(II) (1995)
N.J. Stat. Ann. § 26:2H-54(e) (West 1995)
N.M. Stat. Ann. § 24-7-8 (Michie 1996)
N.Y. Pub. Health Law § 2989(3) (McKinney 1995) (durable power of attorney for health care)
N.C. Gen. Stat. § 90-320(b) (1995)
N.D. Cent. Code § 23-06.4-01 (1995)
N.D. Cent. Code § 23-06.5-01 (1995) (durable power of attorney for health care)
Ohio Rev. Code Ann. § 2133.12(d) (Baldwin 1996)
Okla. Stat. Ann. tit. 63, § 3101.12(g) (West 1995)
Or. Rev. Stat. § 127.570 (1995)
20 Pa. Cons. Stat. Ann. § 5402(b) (1995)
R.I. Gen. Laws § 23-4.10-9(f) (1995) (durable power of attorney for health care)
R.I. Gen. Laws § 23-4.11-10(f) (1995)
S.C. Code Ann. § 44-77-130 (Law. Co-op. 1993)
S.D. Codified Laws Ann. § 34-12D-20 (1996)
Tenn. Code Ann. § 32-11-110 (1995)
Tex. Health & Safety Code Ann. § 672.020 (West 1995)
Utah Code Ann. § 75-2-1118 (1995)
Vt. Stat. Ann. tit. 18, § 5260 (1995)
Va. Code Ann. § 54.1-2990 (Michie 1995)
Wash. Rev. Code Ann. § 70.122.100 (West 1995)
W. Va. Code § 16-30-10 (1995)
Wis. Stat. Ann. § 154.11(6) (West 1995)
Wyo. Stat. § 3-5-211 (1995) (durable power of attorney for health care)
Wyo. Stat. § 35-22-109 (1995)

APPENDIX C

This appendix lists the forty-five states that criminalize assisted suicide, either by statute or judicial decision.

The following thirty-seven states and territories have statutes that explicitly impose criminal penalties for assisting a suicide:

Alaska Stat. § 11.41.120(a)(2) (1995)
Ariz. Rev. Stat. Ann. § 13-1103(A)(3) (1995)
Ark. Code Ann. § 5-10-104(a)(2) (Michie 1995)
Cal. Penal Code § 401 (West 1995)
Colo. Rev. Stat. § 18-3-104(1)(b) (West 1995)
Conn. Gen. Stat. Ann. § 53a-56(a)(2) (West 1995)
Del. Code Ann. tit. 11, § 645 (1995)
Fla. Stat. Ann. § 782.08 (West 1995)
Ga. Code Ann. § 16-5-5(b) (1995)
Haw. Rev. Stat. § 707-702 (1995)
Ill. Comp. Stat. ch. 720, para. 5/12-31 (Smith-Hurd 1995)
Ind. Code Ann. § 35-42-1-2.5(b) (West 1995)
Iowa Code Ann. §§ 707A.2, 707A.3 (West 1996)
Kan. Stat. Ann. § 21-3406 (1995)
Ky. Rev. Stat. Ann. § 216.302 (Baldwin 1995)
La. Rev. Stat. Ann. § 14:32.12 (West 1995)
Me. Rev. Stat. Ann. tit. 17-A, § 204 (West 1995)
Minn. Stat. Ann. § 609.215 (West 1995)
Miss. Code Ann. § 97-3-49 (1993)
Mo. Ann. Stat. § 565.023(1)(2) (Vernon 1995)
Mont. Code Ann. § 45-5-105 (1993)
Neb. Rev. Stat. § 28-307 (1995)
N.H. Rev. Stat. Ann. § 630:4 (1995)
N.J. Stat. Ann. § 2C:11-6 (West 1995)
N.M. Stat. Ann. § 30-2-4 (Michie 1995)
N.Y. Penal Law § 120.30 (McKinney 1995)
N.Y. Penal Law § 125.15 (McKinney 1995)
N.D. Cent. Code § 12.1-16-04 (1995)
Okla. Stat. Ann. tit. 21, § 813 (West 1995)
Or. Rev. Stat. § 163.125(b) (1995)
18 Pa. Cons. Stat. Ann. § 2505 (1995)

P.R. Laws Ann. tit. 33, § 4009 (1990)
S.D. Codified Laws Ann. § 22-16-37 (1996)
Tenn. Code Ann. § 39-13-216 (1995)
Tex. Penal Code Ann. § 22.08 (West 1995)
V.I. Code Ann. tit. 14, § 2141 (1994)
Wash. Rev. Code Ann. § 9A.36.060 (West 1995)
Wis. Stat. Ann. § 940.12 (West 1995)

The following two states have negligent homicide statutes broad enough to penalize assisting a suicide: Ala. Code § 13A-6-4 (1995); and Wyo. Stat. § 6-2-107 (1995).

The following six states have case law authorizing the imposition of criminal penalties for assisting a suicide: *McMahan v. State*, 168 Ala. 70, 73, 53 So. 89, 91 (1910); *Commonwealth v. Mink*, 123 Mass. 422, 428-29 (1877); *Commonwealth v. Bowen*, 13 Mass. 356, 358 (1816); *People v. Kevorkian*, 447 Mich. 436, 493-97, 527 N.W. 2d 714, 738-39 (1994), *cert. denied*, 115 S. Ct. 1795 (1995); *State v. Willis*, 255 N.C. 473, 477, 121 S.E.2d 854, 856-57 (1961); *Blackburn v. State*, 23 Ohio St. 146, 163 (1872); and *State v. Jones*, 86 S.C. 17, 22, 47, 67 S.E. 160, 162, 165 (1910).

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No. 96-110

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ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

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TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF AUTHORITIES iv

INTEREST OF THE *AMICUS* 1

SUMMARY OF THE ARGUMENT 2

ARGUMENT 3

I. The Right of Mentally Competent Adults in the End-Stages of a Terminal Illness To Obtain Medical Treatment Intended To End Life Is Essential to Preserve Human Dignity in Dying 4

A. The Term "Physician-Assisted Suicide" Colors The Issue 4

B. Individual Patient's Conditions Demonstrate That Treatment Intended to End Life Can Be Essential To Dying With Dignity 5

C. Protocols Will Offset The Potential For Abuse 7

II. End-Of-Life Decisions Should Follow Protocols Intended To Respect The Dignity Of Patients And The Sanctity Of The Patient-Physician Relationship 9

A. The Patient Self-Determination Act Proves That Advance Directives Are An Effective Means To Express Patients' Treatment Decisions 12

B. Healthcare Institutions Use Protocols That Promote Compliance With Patients' Treatment Decisions, And Committees That Assist In The Resolution Of Bioethical Disputes 13

C. The *Uniform Rights Of the Terminally Ill Act* And The *Uniform Health Care Decisions Act* Effectively Regulate Treatment Decision-Making 17

D. The *Oregon Death With Dignity Act* And *The Australian Rights Of The Terminally Ill Act* Are Examples Of Existing Legislation On This Issue 19

III. The Right To Treatment Intended to End Life Is Consistent With Traditional Notions Of Liberty-Based Rights Secured By The Due Process Clause 21

A. The Supreme Court Has Long Recognized An Individual's Right To Personal Autonomy And Bodily Integrity, Which Principles Underlie The Right Sought By Respondents 22

B. ACLM's Position Does Not Infringe Upon The Integrity Of The Medical Profession 26

C. The Treatment At Issue Here Is Consistent With Treatment Long-Provided By Physicians 27

IV. Conclusion 28

Appendix A.

A-1 *Compassion in Dying* Petitioners' Letter of Consent to File *Amicus* Brief

A-2 *Quill* Petitioner State of New York's Document of Consent to File *Amicus* Brief

A-3 *Quill* Petitioner County of New York's Letter of Consent to File *Amicus* Brief

A-4 *Compassion in Dying* Respondents' Letter of Consent to File *Amicus* Brief

A-5 *Quill* Respondents' Letter of Consent to File *Amicus* Brief

Appendix B

B-1 Choice In Dying, *Diagram of State Statutes Governing Living Wills and Appointment of Healthcare Agents* (1996)

Appendix C

C-1 American Hospital Association's *Policy and Statement on Patient's Choice of Treatment Options* (1985)

TABLE OF AUTHORITIES

Page

Cases:

Cruzan v Director, Missouri Department of Health, 497 U.S. 261 (1990) . . . . . *passim*

Compassion In Dying v State of Washington, 79 F.3d 790 (9th Cir. 1996) . . . . . *passim*

Lee v State, 86 F.Supp. 1491 (D.Or. 1994) 19

Olmstead v United States, 277 U.S. 438 (1928) (Brandeis, J., dissenting) 23

Planned Parenthood of Southeastern Pennsylvania v Casey, 505 U.S. 833 (1992) 5,24

Quill v Vacco, 80 F.3d 716 (2d Cir. 1996) . . . . . *passim*

Roe v Wade, 410 U.S. 113 (1973) 8,26

Schloendorff v Society of New York Hosp., 105 N.E. 92 (N.Y. 1914) 23

Union Pac. Ry. Co. v Botsford, 141 U.S. 250 (1891) 5,23

Statutes:

Cal. Health & Safety Code §7188 (West Supp. 1996) . 15

Northern Territory of Australia Rights of the Terminally Ill Act 19-20

Northern Territory of Australia, Care of the Dying Consultation Bill (1996) 20-21

N.Y. Penal Law §125.15(3) (McKinney 1987) 4

Oregon Death With Dignity Act, Ore.Rev.Stat. ch. 127.800 §1.01 *et seq.* (1995) 19-20

Ore.Rev.Stat. ch. 127.515(4)(e) (Supp. Part 2, 1994) 15

Patient Self Determination Act, 42 U.S.C. §1395 cc(f) (West 1992 & Supp. 1996) 12

Uniform Healthcare Decisions Act, 9 U.L.A. 220 (1996) 18-19

Uniform Rights of the Terminally Ill Act, 9B U.L.A. 609 (1987) 18

Wash.Rev.Code §9A.36.060 (1980) 4

Other Authorities:

American Hospital Association's *Policy and Statement on Patient's Choice of Treatment Options* (1985) 13

Appelbaum and Gisso, *Assessing Patients' Capacity to Consent to Treatment*, 319 N.Eng.J.Med. 1635 (1988) 14

Choice In Dying, *Diagram of State Statutes Governing Living Wills and Appointment of Healthcare Agents* (1996) 10

Cohen, *Realism, Law and Aging*, 18 Law, Medicine and Health Care 183 (Fall 1990) (citing Spencer, U.S. Bureau of the Census, *Projections of the Populations of the United States by Age, Sex, and Race: 1983-2080, in Current Population Reports*, Series P-25 No. 952 (Mar. 1984)) 11

Cohen, *Realism, Law and Aging*, 18 Law, Medicine and Health Care 183 (Fall 1990) (citing *Aging Americana: Trends and Projections*, 1987-1988 U.S. Senate Special Comm. on Aging. . . . 11

Cohen, Realism, Law and Aging, 18 Law, Medicine and Health Care 183 (Fall 1990) (citing *Clinically Diagnosed Alzheimer's Disease: An Epidemiological Study in Community Population of Older Persons*, 262 JAMA 2551 (1989) . 11

Drynski, et al, *How Informed Can Consent Be? New Light on Comprehension Among Elderly People Making Decisions About Enteral Tube Feeding*, 34 The Gerontologist 36 (1994) 15

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Miller et al., *Regulating Physician-Assisted Death*, 331 N.Eng.J.Med. 119 (1994) 15,17

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Quill, et al., *Care of the Hopelessly Ill - Proposed Clinical Criteria*, 327 New Eng. J.Med. 1380 (1992) 9

C. Sabatino, *Symposium: Trends In Health Care Decisionmaking, Etc.*, 53 Md.L.Rev. 1238 (1994) 18

Seneca, Roman Orator, *circa* 3 B.C. - A.D. 65 . . 3,28,29

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Webster's Third New International Dictionary, 2286 (1981) 4

INTEREST OF THE *AMICUS*

The American College of Legal Medicine ("ACLM") respectfully submits this brief as an *amicus curiae* pursuant to Rule 37 of the Rules of the Supreme Court of the United States, and submits it in each of these cases. ACLM's position in this brief directly supports neither the petitioners nor the respondents in either case, instead advocating a neutral position that ACLM believes would best achieve the optimal outcome in these cases. ACLM has received the consent of all parties to submit this brief pursuant to the applicable rules of this Court. *See* Appendix A.

Founded in 1960, ACLM is an organization of professionals concerned with issues arising at the convergence of law and medicine. ACLM's membership consists of about 1300 professionals, including physicians and scientists in most every specialty, management and employees in various healthcare fields, and plaintiff, defense, corporate and public interest attorneys. ACLM is officially recognized by the American Medical Association ("AMA") as the society that represents legal and medical specialists, and ACLM holds a seat in the AMA House of Delegates.

ACLM's interest in these cases derives from the current prominence of the issue commonly known as physician-assisted suicide, coupled with a fear that advocates of each of the polar positions on this divisive issue fail to adequately appreciate the merits of the other. ACLM's interest is additionally driven by the fact that the aging of the "baby-boomer" generation will force an increasing number of individuals into end-of-life treatment decisions, particularly as continued advances in medical science enable physicians to prolong life notwithstanding the quality of that life. ACLM believes that, ideally, law and policy ought to amalgamate the most significant concerns on each side of this issue, in a manner that responsibly and pragmatically accounts for society's traditional abhorrence of suicide, without sacrificing the interests of those who endure the unfathomable pain and suffering often associated with the end-stages of terminal illnesses. ACLM asserts that there is a middle-ground that will both protect the state's and society's interest in promoting and preserving meaningful life, and serve the interests of those who are some of the most desperate individuals in our society. Importantly, ACLM respectfully submits that this Court can reach such a balance within a constitutional framework premised upon its past decisions.

SUMMARY OF THE ARGUMENT

ACLM believes that a mentally-competent adult in the end-stages of a terminal illness owns the right to control end-of-life medical treatment decisions, such as refusing and terminating unwanted medical treatment -- a right recognized and protected by this Court in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990). ACLM urges this Court to interpret end-of-life treatment decisions for such patients to include the right to obtain treatment intended to end life.

ACLM recognizes, however, that the state and society have a legitimate and compelling interest in ensuring that the right to control end-of-life treatment decisions is not abused by patients, their physicians and families, or interested third-parties. To protect against such abuse, ACLM believes it essential to regulate, through protocols, the administration of treatment intended to end life. Paramount, too, is strict enforcement of these protocols, through means to be established by the states in collaboration with the healthcare community.

ACLM's position is premised necessarily on the efficacy of these protocols. In this regard, ACLM presents to this Court for its consideration a compilation of the many varieties of healthcare-related regulations and protocols already in place. The benefits of consideration of these protocols are three-fold: First, it demonstrates that comprehensive regulations on end-of-life medical treatment imposed by

federal and state statutes, as well as by the healthcare community itself, not only exist, but also have effectively allowed for the responsible administration of end-of-life treatment and care. Second, many of these regulations in their current form would apply to the specific treatment at issue in these cases, *i.e.*, treatment intended to end life. Third, to the extent that existing regulations would not apply to the treatment at issue here, the regulations nevertheless provide a framework upon which applicable restrictions can and should be crafted.

Finally, ACLM acknowledges the context in which the instant issue arises, *i.e.*, a challenge to the constitutionality of statutes criminalizing physician treatment intended to end life. ACLM demonstrates herein that the right it asks this Court to recognize in no way constitutes a radical expansion of the rights already secured by our Constitution, but rather is consistent with Fourteenth Amendment rights that already have been recognized by this Court.

ARGUMENT

> I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leave my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know that if I must suffer without hope of relief, I will depart, not through fear of the pain itself, but because it prevents all for which I would live.
>
> Seneca
> Roman Orator
> *circa* 3 B.C. - A.D. 65

I. The Right of Mentally-Competent Adults in the End-Stages of a Terminal Illness To Obtain Medical Treatment Intended To End Life Is Essential to Preserve Human Dignity in Dying.

The issue in these cases -- whether a mentally-competent adult in the end-stages of a terminal illness has a right to medical treatment intended to end life -- creates virulent debate and a division in public opinion equaled by few, if any, other issues of the day; the debate and division, however, are understandable. Proponents on one side argue that what is at stake is perhaps the most fundamental right known to humankind -- the right to control one's body and life; advocates on the other side equate the acts at issue here to suicide by the patient, and to killing by the physician. For this reason, ACLM urges this Court to focus not only upon the constitutional analysis, as of course it must, but also upon the consequences and policy implications of a decision premised upon that analysis.

A. The Term "Physician-Assisted Suicide" Colors The Issue.

Semantics, of course, do not resolve the instant issue. Yet, the term "physician-assisted suicide" is arguably a misnomer that unfairly colors the issue, and for some, evokes feelings of repugnance and immorality. The appropriateness of the term is doubtful in several respects. First, neither the New York nor the Washington statute at issue in these cases contain the phrase "physician-assisted suicide." *See* N.Y. Penal Law §125.15(3) (McKinney 1987); Wash.Rev.Code §9A.36.060 (1980). Second, the word "suicide" itself is defined not only as the "taking of one's own life" but also as the "destruction or ruin of one's own interests." *Webster's Third New International Dictionary*, 2286 (1981). As exemplified in the discussion below, it seems inappropriate to characterize requests for treatment that ends life, made by suffering, terminally-ill patients, as any form of destruction or

ruination of their interests. Assuming a patient's mental competence, and recognizing this Court's long-held commitment to the principles of personal autonomy and free will (*see, e.g., Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891); *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 847, 851 (1992) (both quoted *infra*)), prescribing medication intended to end life in the subject context *serves* -- not destroys or ruins -- a patient's interests. For these reasons, ACLM questions whether the subject statutes even apply to the situation in which a physician cares for a mentally-competent adult in the end-stages of a terminal illness with medical treatment intended to end life. Notwithstanding that fact, ACLM rejects the term "physician-assisted suicide," and instead refers herein to the practice in question as "treatment intended to end life."

B. Individual Patient's Conditions Demonstrate That Treatment Intended To End Life Can Be Essential To Dying With Dignity.

In forming policy on this issue, it is critically important to consider the horrific situation in which, unfortunately, innumerable patients find themselves. These patients' individual stories enlighten us to the experience of dying a slow, painful and agonizing death. Consider the following:

> Jane Doe was a mentally-competent adult in the end-stage of cancer. She endured a cancerous tumor that had wrapped around her right carotid artery, collapsing her esophagus and invading her voice box. The tumor restricted her ability to swallow and prevented her from eating anything but very thin liquids in extremely small amounts. Eventually, she was placed on a feeding tube, which caused serious additional medical problems.

Quill v. Vacco, 80 F.3d 716, 720 (2d Cir. 1996); *see also Cruzan*, 497 U.S. 261, 289 (O'Connor, J., concurring)

("[b]ecause of the discomfort such a [feeding] tube causes, [m]any patients need to be restrained forcibly and their hands put into large mittens to prevent them from removing the tube" (citation omitted)).

> William A. Barth was a mentally-competent adult in the end-stage of AIDS, who had endured years of radiation and chemotherapy treatment for cancer. As a result of AIDS, he contracted (a) cytomegalovirus in his stomach and colon which caused severe diarrhea, fevers and wasting; (b) a type of parasitic infection which independently caused severe diarrhea, extreme abdominal pain, nausea and additional significant wasting; (c) another type of parasitic infection for which there was no treatment; and (d) pneumonia, for which he regularly took infusion therapy treatment that was so toxic he vomited with each infusion.

Quill, 80 F.3d 716, 720.

These are the histories of just two of the plaintiffs in these cases, each of whom filed their lawsuit asserting a right to care and treatment to end life, and each of whom has died from disease during the pendency of these cases. *Compassion in Dying v. State of Washington*, 79 F.3d 790, 795 (9th Cir. 1996); *Quill*, 80 F.3d at 722. Repeating these stories is essential to recognizing an inescapable conclusion: Individuals who seek care and treatment intended to end life include human beings who suffer a torturous existence. Notwithstanding the impact of descriptive language that ingrains these patients' suffering, the extent of their misery is, by its nature, beyond the comprehension of anyone not in their position. While these stories surely evoke feelings of compassion, no one should pretend to know definitively whether he or she would desire life-ending care and treatment in a like situation. Moreover, from these patients' situations, we also understand that they suffered excruciating pain beyond

the bounds of non-lethal doses of pain medication, and further, that they endured the indignities that come with failing bodies. For each, death was imminent and certain, but for each, every moment of that existence was torturous.

It is also significant to realize that these histories are not a few isolated situations, which, for better or worse, are mooted by these patients' respective deaths. The average age of the population of the United States is rising, while at the same time, advances in medical science enable physicians to maintain life long beyond the stage at which fatal disease causes physical incapacitation and unendurable pain. As Professor George P. Smith II noted,

> Life is not an amaranth, the imaginary flower that never fades. For all too many, the "benefits" of modern medicine and treatment extend the fading process with tragic withering, discoloration and odor.

Smith, *All's Well That Ends Well: Toward a Policy of Assisted Rational Suicide or Merely Enlightened Self-Determination?* 22 U.C. Davis L.Rev. 275, 281 (1989) ("Smith"). Without life-ending treatment, a mentally-competent patient in the end-stages of a terminal illness is left with an option of a conscious existence that is excruciatingly painful and devoid of dignity, or alternatively, medications that diminish or end consciousness, thereby rendering continued life meaningless. ACLM respectfully submits that, in a free, humane and civil society, this is no option at all. For patients in this condition, the right to care and treatment intended to end life is necessary to avoid pointless suffering and maintain personal dignity in the final phase of their life.

C. Protocols Will Offset The Potential For Abuse

As the Ninth Circuit aptly noted in its decision on appeal, "[r]ecognition of any right creates the possibility of abuse."

Compassion in Dying, 79 F.2d at 831. Indeed, the state has a legitimate and compelling interest to ensure that the right to control end-of-life treatment decisions is not abused by patients, their physicians and families, or interested third-parties. But, as this Court recognized in *Cruzan*, where such potential for abuse exists, the state simply must "guard against potential abuses." 497 U.S. 261, 281.

ACLM agrees. To avoid abuses, it is incumbent upon government in collaboration with the healthcare community to establish regulations on the administration of treatment intended to end life. As shown in greater detail *infra*, there are abundant mechanisms in existence today which serve to regulate healthcare and treatment -- some in the form of federal and state legislation, and many in the form of protocols established by the healthcare community itself.

Critical, too, is the enforcement of these statutes, regulations and protocols. For example, "[i]f an individual [physician] abuses the privilege of exercising proper medical judgment" in administering treatment intended to end life, "the usual remedies, judicial and intra-professional, are available." *Roe v. Wade*, 410 U.S. 113, 167 (1973).

Which regulatory mechanisms, protocols and associated penalties will most successfully avoid abuses in the context of the right at issue here is best-determined through the collaborative initiatives of the state and the healthcare community. Obviously, penalties for any violation of law, regulation or protocol should be commensurate with the seriousness of the offense. And although this Court's decision in *Cruzan*, too, recognized a right which seemed wrought with the potential for abuse, this Court expressed its justified confidence in the ability of states and the healthcare community to craft appropriate regulations:

> Today we decide only that one State's practice does not violate the Constitution; the more challenging

> task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States....

Cruzan, 497 U.S. 261, 292 (citation omitted). As shown *infra*, states and the healthcare community have responded impressively with respect to regulating the withdrawal of life-support systems. Contrary to the early critics of *Cruzan*, since this Court rendered its decision in that case, there has *not* been a public outcry of abuse, nor do we hear of utilizing *Cruzan* to endanger the elderly, infirm, disabled and indigent. This oft-heard slippery slope argument is unfounded due to the substantiated fact that the states and the healthcare community possess the skill and know-how to manage and administer end-of-life treatment decisions. Simply stated, the slippery slope proved to be nothing but an imaginary hill. Moreover, to doubt now the collective wisdom of the states and healthcare community would be to reject the premise of this Court's holdings in *Roe v. Wade*, *Cruzan* and *Casey*.

II. End-Of-Life Decisions Should Follow Protocols Intended To Respect The Dignity Of Patients And The Sanctity Of The Patient-Physician Relationship.

As a result of the "growing medicalization of death" (Smith, *supra* at 359; *see also* Quill, *et al.*, *Care of the Hopelessly Ill - Proposed Clinical Criteria*, 327 N.Eng.J.Med. 1380 (1992)), the responsibility of the healthcare community in this era of medical technology is profound and daunting. The most sacred patient-physician relationship, once established and seen as a collaborative effort, should not be forced to end at a time when an individual's values and integrity are at their most critical juncture. The physician's ability to care for a patient is at no time more meaningful than when the doctor affirms the dignity of the patient through assistance in end-of-life treatment decisions.

ACLM, however, advocates that a physician assist a patient in end-of-life treatment decisions only through the use of strict protocols, intended to evaluate a patient's medical, physical, emotional, psychological and social state of being. Prior to the administration of any treatment intended to end life, a physician should be required to thoroughly discuss all medical options available to the patient, if any, including palliative care. ACLM, too, is cognizant of, and concerned over, the potential abuse of the elderly, infirm and indigent arising out of end-of-life treatment decisions. To date, however, existing protocols regarding the termination or withdrawal of life-sustaining treatment have vastly decreased the possibility of such abuse.

For example, federal and state advance directive statutes are prevalent throughout the country, and they assist individuals in documenting and implementing their end-of-life decisions.[1] As of March, 1996, for instance, almost every state authorizes either living wills or the appointment of a healthcare agent, or both.[2] *See* Choice In Dying, *Diagram of State Statutes Governing Living Wills and Appointment of Healthcare Agents* (1996) (Appendix B). In order to implement these advance directives, healthcare facilities

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1 An Advance Directive is an "explicit statement by a decisionally-capable adult, either written or communicated orally, that states preference for medical care in the future if the person should no longer be able to consider the medical options and communicate a preference. Dubler and Marcus, *Mediating Bioethical Disputes* 77 (1994).

2 A living will relating to the use of life sustaining treatment specifies under what medical conditions a physician is instructed by a patient to withhold or withdraw treatment. Such conditions usually include an incurable and irreversible condition that without the administration of life-sustaining treatment, would cause the death of a patient.

A health care agent also referred to as an attorney-in-fact, judicially appointed guardian or a power of attorney for healthcare, is an individual appointed by the patient to make decisions on the patient's behalf regarding the withholding or withdrawal of life-sustaining treatment whenever the patient is no longer capable of making his or her own treatment decisions.

employ protocols and ethics committees[3] that enable medical and nursing staff to comply with patients' pre-determined medical treatment decisions.

The existence of such advance directives and protocols to implement them is more important than ever before.[4] It is estimated that, by 2050, over 20% of our population will have reached the age of 65 or older (compared to 4% in the early 1900's). Cohen, *Realism, Law and Aging*, 18 Law, Medicine and Health Care 183, 189 (Fall 1990) (citing Spencer, U.S. Bureau of the Census, *Projections of the Populations of the United States by Age, Sex, and Race: 1983-2080, in Current Population Reports*, Series P-25 No. 952 (Mar. 1984)). Moreover, the number of individuals over 85 living in nursing homes will increase from 22% in 1985 to triple that number in 2010 (Cohen, *supra* at 189, citing *Aging Americana: Trends and Projections*, 1987-1988 U.S. Senate Special Comm. on Aging, p. 118), many of whom may be suffering from Alzheimer's Disease. *Id.*, citing Evans, *et al*, *Clinically Diagnosed Alzheimer's Disease: An Epidemiological Study in Community Population of Older Persons*, 262 JAMA, 2551-2556 (1989). "Baby-boomers" who are currently debating the issue of end-of-life treatment decisions will be faced with this very issue within the next twenty to fifty years. Treatment decisions to end life will no longer be legal and medical issues as much as they will be societal issues -- issues that must be confronted, and these cases provide for this opportunity.

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3 An ethics committee is a "[c]onsultative committee in a hospital or other institution whose role is to analyze ethical dilemmas and to advise and educate health care providers, patients and families regarding difficult treatment decisions", including end-of-life decisions. Dubler & Marcus *supra* at 79; *see also* Hastings Center, *Guidelines on Termination of Life Sustaining Treatment and the Care of the Dying*, *supra*, 100-105 (1987).

4 A recent study confirmed that patients suffering from a terminal illness *frequently* contemplate end-of-life medical treatment issues. Emanuel, *et al.*, *Euthanasia and Physician Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists and the Public*, 347 Lancet 1805-10 (1996).

A. The Patient Self-Determination Act Proves That Advance Directives Are An Effective Means To Express Patients' Treatment Decisions.

In response to *Cruzan*, the legal community in collaboration with healthcare experts created and enacted the Patient Self-Determination Act ("PSDA") (42 U.S.C. §1395 cc(f) (West 1992 & Supp. 1996)). Since its enactment, the PSDA has served as the procedural linchpin upon which healthcare institutions, physicians and patients currently rely with respect to end-of-life treatment options and decisions. The PSDA requires *all* hospitals, skilled nursing facilities, home health agencies, hospital programs and health maintenance organizations (HMOs), that receive Medicare or Medicaid funding, to educate patients about advance directives. Specifically, healthcare facilities must provide patients, upon admission, with information regarding their state-law rights regarding end-of-life decisions, including the right to refuse or accept any form of medical treatment, and the right to exercise an advance directive (if one has not already been prepared). Whether the patient has executed an advance directive must be documented in the patient's medical chart to ensure compliance with the patient's direction. Patients are not required to execute advance directives, and their medical care is in no way conditioned upon their execution of one. The PSDA also recognizes that, for moral, ethical or religious reasons, medical institutions or medical staff may not be willing to comply with any particular form of treatment set forth in an advance directive. The PSDA, therefore, requires that patients be notified of these beliefs.

Furthermore, the PSDA requires that institutional staff, as well as the community at large, be provided with information regarding advance directives. This aspect of the PSDA is critical if patients, families, healthcare institutions and communities are to understand the impact advance directives can have on individuals, and on society as a whole.

ACLM believes that the PSDA should be applicable to all end-of-life treatment decisions, including treatment intended to end life.

B. Healthcare Institutions Use Protocols That Promote Compliance With Patients' Treatment Decisions, And Committees That Assist In The Resolution Of Bioethical Disputes.

For decades, healthcare institutions have taken a leading role in recognizing and lending support to patient decision-making. For instance, hospitals have established policies that assist medical staff in determining a patient's decision-making capacity, including a patient's ability to make end-of-life treatment choices. Similarly, the American Hospital Association's *Policy and Statement on Patient's Choice of Treatment Options* (1985) (*see* Appendix C) provides that "[h]ealth care decision making should be based on a collaborative relationship between the patient and the physician" and that "institutional methods should be established to reasonably assure that the patient may exercise this authority on the basis of relevant information necessary to make a sufficient voluntary and informed decision." This policy also provides safeguards whereby patients can make decisions regarding the withholding and withdrawal of medical treatment.

Furthermore, the Joint Commission on Accreditation of Health Care Organizations ("JCAHO"),[5] and by reference, the federal Medicare program, has set standards to assist healthcare facilities in creating and implementing policies and procedures with respect to obtaining a patient's informed

5 JCAHO is a private, voluntary accrediting organization, the principle roles of which include establishing standards for the operation of healthcare facilities, recognizing compliance with these standards through issuance of certificates of accreditation, and conducting surveys and accreditation programs that encourage and assist such facilities in promoting efficient, high-quality patient care.

consent to treatment. JCAHO, *Comprehensive Accreditation Manual for Hospitals, Patient Rights and Organization Ethics*, RI 1.2.1 (1996). Pursuant to these standards, the ability of a patient to provide informed consent is conditioned upon the following factors: a patient must (1) have the capacity to make reasonable judgments; (2) have a clear understanding of the nature of his or her disease and prognosis, as well as an understanding of the risks and benefits associated with proposed treatment alternatives; and, (3) make decisions voluntarily and without any degree of coercion. Appelbaum and Gisso, *Assessing Patients' Capacity to Consent to Treatment*, 319 N.Eng.J.Med. 1635-1638 (1988).

Particularly relevant to the instant issue is a physician's ability to determine a patient's capacity to give informed consent where that patient suffers excruciating pain, dementia or depression. In order to gauge a patient's true desires on treatment, healthcare facilities employ the use of specialists, including pain-management specialists, gerontologists, psychiatrists and oncologists. Gordon and Linger, *Decisions and Care at the End of Life*, 346 Lancet 163-66 (1995).

Physicians who treat terminally-ill patients also consult with specialists knowledgeable in the use of palliative care, also known as "comfort care." "Palliative care" refers to medical, surgical and other interventions designed to alleviate "suffering, discomfort and dysfunction, whether physical or not, but not to cure". Hastings Center, *Guidelines on the Termination of Life-Sustaining Treatment and the Care of the Dying* 141 (1987); *see also*, *Id.*, 73-75 ("Since patients know most fully the extent of their suffering and their need for relief, their wishes about palliative care and pain relief should guide professionals. Whenever possible, the patient, together with the responsible healthcare professional, should determine the degree and type of palliative and pain relief...."). Palliative care is utilized most often in hospice programs. The goal of this type of care is to relieve the patient's symptoms, and ease the process of dying by providing care and support

that enhance the quality and meaning of the patients' remaining life...." Miller et al., *Regulating Physician-Assisted Death,* 331 N.Eng.J.Med. 119 (1994).

Although some express concern over the ability of infirm and elderly patients to fully-comprehend treatment options and the impact of their treatment decisions, a comprehensive study has shown that such patients, in fact, do understand healthcare information, and that they are capable of making decisions regarding advance directives, through the use of simplified story books and discussion paralleling the patient's level of comprehension. Drynski, et al, *How Informed Can Consent Be? New Light on Comprehension Among Elderly People Making Decisions About Enteral Tube Feeding,* 34 The Gerontologist 36-43 (1994).

Furthermore, several states, including California, require skilled nursing facility patients to execute advance directives in the presence of patient advocates or ombudspersons (designated by the state), who specialize in treating the aged and infirm. *See, e.g.*, Cal. Health & Safety Code §7188 (West Supp. 1996). *See also* Ore.Rev.Stat. ch. 127.515(4)(e) (Supp. Part 2, 1994). This policy serves as yet another safeguard to the threat of abuse or coercion.

In fact, even prior to *Cruzan* and the PSDA, hospitals employed policies and procedures governing the acquisition of informed consent from the aged and infirm, and governing the withdrawal of life-sustaining treatment. Likewise, JCAHO, since January, 1988, has established hospital standards regarding the withholding and withdrawal of resuscitative services and life-sustaining treatment.

As these issues became more complex, hospitals began to address the moral, ethical and religious concerns relating to a patient's decision either to withdraw or forego treatment. Again, the healthcare community addressed this new-found problem effectively. Ethics committees were developed to

assist medical staff and patients in resolving these moral, ethical and religious conflicts arising out of a patient's treatment decisions. *See, e.g.*, Osborne, *Physician Decisions Regarding Life Support in the Intensive Care Unit; Ethics in Cardiopulmonary Medicine*, 101 Chest 135-145 (1992). Ethics committees became widely utilized after JCAHO published standards for hospitals regarding the recognition of bioethical disputes and establishment of policies and procedures to resolve these conflicts. JCAHO, *Comprehensive Accreditation Manual for Hospitals, Patient Rights and Organization Ethics*, RI 1.2.3 at 76 (1996).

Depending on the milieu of an institution, ethics committees serve a variety of functions, including, (a) reviewing a patient's case to confirm that individual's diagnosis and prognosis; (b) providing a forum for discussing broader social and ethical concerns raised by a particular case; (c) educating professional staff how to identify, frame and resolve ethical problems; (d) formulating policy and guidelines regarding such decisions; and (e) reviewing decisions made by others (such as physicians and surrogates) about the treatment of specific patients or make such decisions themselves. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life Sustaining Treatment*, 160 (1983).

Cutting-edge innovative programs have also assisted hospitals and bioethics committees in mediating bioethical disputes and training hospital staff to facilitate resolution of disagreements among patients, family and medical staff. For example, the Center for Medical Ethics and Mediation, located in San Diego, California, currently teaches healthcare professionals and staff in hospitals and managed care facilities the theory and skills utilized in mediation of bioethical and health law disputes arising between medical staff and patients. The Center for Medical Ethics and Mediation, *Kaiser Permanente Re-engineers for Conflict-Positive Customer Relations*, 4 Pontis 1 (Spring 1996). Similarly, the Program

for Health Care Negotiation and Conflict Resolution at the Boston University School of Public Health collaborated with Montefiori Medical Center in New York to create a prototype of alternative dispute resolution techniques, particularly mediation, that could be used to resolve bioethical disputes in the hospital setting. Dubler & Marcus, *Mediating Bioethical Disputes*, 1994.

In response to the recognized need to educate physicians and healthcare practitioners regarding palliative and life-ending medical treatment,[6] palliative-care committees serve as an example of overseeing treatment decisions intended to end life. These committees, composed of lay members and professionals, "would be responsible for educating clinicians and the public about methods of comfort care (including pain management), ethical standards of informed refusal and discontinuation of life-sustaining treatment and the option of physician assisted death." Miller, *et al., Regulating Physician Assisted Death*, 331 N.Eng.J.Med. 119, 121 (1994).

C. The *Uniform Rights of the Terminally Ill Act* And The *Uniform Health Care Decisions Act* Effectively Regulate Treatment Decision-Making.

As stated, *supra*, the 1970's and 1980's saw a flurry of activity as states attempted to created advance directive statutes that recognized the need of their citizens to personally control their healthcare decision-making.

The increasing interest in advance directives served as a catalyst for the National Conference of Commissioners on Uniform State Laws ("Commissioners") to draft and approve

6 According to a 1992-93 survey conducted by the American Medical Association, of the nation's 126 medical school, only five have a required course on the care of dying patients. Gordon, *Perspective on Assisted Suicide: Doctors are Remiss at the Death Bed;* L.A. Times, Oct. 10, 1996 at B9.

the 1985 Uniform Rights of Terminally Ill Act ("Act") in 1985. 9B U.L.A. 609 (1987). Although the Act drew upon existing legislation, the Commissioners drafted language that was "simple, effective, and acceptable to those individuals desiring to execute a declaration and to physicians and health care facilities whose conduct [would] be affected. "The Act was crafted to avoid statutory inconsistencies that characterized earlier statues and provided that advance directives executed in one state would be reciprocally recognized in other states. *Id.* Various states have adopted some form of living will or advance directive based upon the model Act.

By 1993, as a result of *Cruzan*, the Commissioners created the Uniform Health Care Decisions Act, ("Health Care Decision Act"), which effectively superseded the Act. 9 U.L.A. 220 (1996). The intention of the drafters of the Health Care Decisions Act was to "pave a health care decisionmaking superhighway." C. Sabatino, *Symposium: Trends in Health Care Decisionmaking, Etc.*, 53 Md.L.Rev. 1238-1239 (1994). The Commissioners deleted such "preconditions such as certification of diagnosis of a terminal condition or permanent unconsciousness, the need for life-sustaining procedures, and special needs for nutrition and hydration or pregnancy." *Id.* In fact, the Health Care Decision Act not only includes language regarding advance directives, it includes all medical decisionmaking even if an advance directive is not executed. The patient may also designate a healthcare agent to make any treatment decisions for the incapacitated patient. Health Care Decision Act, 7(b). Further, recognizing the vulnerability of patients confined to long-term residential healthcare facilities, the Health Care Decisions Act precludes owners, operators or employees of such facilities from serving as agents unless they are related to the resident by blood, marriage or adoption. *Id.* at §2(b). With respect to the validity of sister-state advance directives, the Health care Decisions Act simply states that if an advance

directive complied with the Health Care Decisions Act, it is valid regardless where it was executed. *Id.* at §2(h).

The Commission's approach makes an important point: the autonomy of the patient and the patient's ability to communicate with his or her doctor and any health care decisions made as a result of this communication must be honored. The Commissioners also serve as an example to this Court where one body, expert in the area of advance directives, can draft model legislation that can serve as a template for individual state legislatures.

D. The *Oregon Death With Dignity Act* And The *Australian Rights Of The Terminally Ill Act* Are Examples Of Existing Legislation On This Issue.

Currently, few statutes anywhere in the world specifically authorize physicians to assist patients in ending their lives. Two of these statutes are the Oregon Death With Dignity Act, Ore.Rev.Stat. ch. 127.800 §1.01 *et seq.* (1995) ("Oregon Act"), and the Northern Territory of Australia Rights of the Terminally Ill Act ("Australian Act"). Each provides substantial protection for patients and physicians.

The Oregon Act, passed in November 8, 1994, is the first American statute permitting and regulating treatment intended to end life.[7] The Oregon Act provides, *inter alia*, that (i) a witness to any advance directive regarding end-of-life treatment, executed by a patient in a long-term facility, must be an "individual designated by the facility [who] has the qualifications specified by the Department of Human Resources;" (ii) patients must be made aware of feasible alternatives including comfort care, hospice care and pain

7 In *Lee v State*, 86 F.Supp. 1491, 1493 (D.Or. 1994), the district court imposed a preliminary injunction, ruling that substantial constitutional issues need be resolved before the Oregon Act may be implemented. This statute, nonetheless, provides an interesting model for the regulation of treatment intended to end life.

control; and (iii) if a physician believes that the patient is suffering from a psychiatric or psychological condition or depression impairing the patient's judgment, the physician shall request that the patient be referred to counseling. Ore.Rev.Stat. ch. 127.810 §2.02(4); ch. 127.815 §301(e); and ch. 127.875 §303 (1995). The Oregon Act, however, fails to address the use of ethics/oversight committees specializing in the treatment of terminally-ill patients -- a proposal that ACLM feels is vitally important.

The Australian Act, on the other hand, is significantly more comprehensive. Under the Australian Act: (1) palliative care options must be made available to the patient, and if this care can bring about a remission in the patient's pain and suffering, the physician shall not assist the patient in ending life; (2) medical treatment is to be confined to the relief of pain and suffering, with the object of allowing the patient to die comfortably; (3) two additional physicians, other than the primary physician, one being a psychiatrist, must examine the patient to determine that the patient's request is not premised upon treatable clinical depression; (4) the physician must be satisfied that the patient has made an informed decisions and has not been coerced to end life; (5) at least 48 hours must elapse between the time the patient requests and the physician provides treatment that will hasten the patient's death; and, (6) the physician must be guided by appropriate medical standards and pharmacological guidelines, and the physician must remain with the patient while assistance is given, and until the death of the patient.

Debate over the Australian statute is far from over. Australia's legislature is now considering a bill entitled *Care of the Dying Consultation Bill*, which would create a committee designed to address the following issues: (a) the extent to which both the health services and the present law provide adequate options for dying with dignity; (b) whether there is sufficient public and professional awareness of pain relief and palliative care available to persons facing prolonged

pain in a terminal illness; (c) whether there is adequate provisions of pain relief and palliative services to persons facing prolonged pain in a terminal illness; (d) whether there is sufficient public and professional awareness of the [country's] *National Death Act* and, if not, what measures should be taken to overcome any deficiency; (e) to what extent, if any, community attitudes towards death and dying may be changing; and (f) to what extent, if any, the law relating to dying needs to be clarified or amended. *See Northern Territory of Australia, Care of the Dying Consultation Bill* (1996).

ACLM believes that regulations regarding treatment decisions intended to end life cannot exist without a structure that has the ability to oversee and evaluate the treatment process, as well as to provide for extensive education of the public regarding the options available to terminally ill patients. Clearly, discussions regarding legal and public policy issues attendant to end-of-life treatment decisions will be ongoing. Nevertheless, the gauntlet is laid. Numerous comprehensive regulations on end-of-life medical treatment imposed by federal and state statutes, as well as by the healthcare community itself, not only exist, but also effectively allow for the responsible administration of end-of-life treatment and care. In fact, many of these regulations in their current form would apply to the specific treatment at issue in these cases, *i.e.*, treatment intended to end life. To the extent they would not so apply, these laws and protocols provide a framework upon which applicable regulations can and should be crafted.

III. The Right To Treatment Intended to End Life Is Consistent With Traditional Notions Of Liberty-Based Rights Secured By The Due Process Clause

In this appeal, petitioners challenge the Second and Ninth Circuit's rulings that the state statutes in question in each of these cases are unconstitutional. The Second Circuit found the New York statute unconstitutional on equal protection

grounds, whereas the Ninth Circuit invalidated the Washington statute as an impermissible deprivation of a patient's liberty rights, *i.e.*, substantive due process rights. As stated *supra*, ACLM questions whether these statutes -- which criminalize promoting or assisting in suicide -- even apply to the situation in which a physician provides treatment intended to end life for a mentally-competent adult in the end-stages of a terminal illness, because arguably, the act in question here is not suicide. Petitioners, however, clearly believe that it is. Assuming *arguendo* the accuracy of that position, ACLM asserts that patients fitting the qualifications repeated throughout this brief are constitutionally-entitled to seek treatment intended to end life under the due process clause of the Fourteenth Amendment. That right, however, like most all rights, is not absolute, and must be appropriately regulated to avoid abuse, particularly in light of the seriousness of abuse in this context, *i.e.*, the potential promotion of patient suicide. Accordingly, ACLM asserts that the subject statutes are unconstitutional *to the extent* that they criminalize, *per se*,[8] treatment intended to end the life of a mentally-competent adult in the end-stages of a terminal illness.

A. The Supreme Court Has Long-Recognized An Individual's Right to Personal Autonomy and Bodily Integrity, Which Principles Underlie The Right Sought By Respondents.

ACLM's position is premised, certainly, upon its belief that the subject treatment should be available for "qualified" patients who seek it. But ACLM's position is also supported by, and consistent with, a long line of Supreme Court decisions which secure the rights of individuals to be free

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8 ACLM does not contend that the subject statutes are unconstitutional to the extent that they criminalize promoting or assisting in suicide generally, but rather, ACLM asserts that they constitute an impermissible infringement on the rights of a mentally-competent adult in the end-stages of a terminal illness to seek from a physician medical treatment intended to end life.

from undue governmental intrusion in the most personal, intimate choices that go to the essence of personhood, personal autonomy and self-determination. For example, in 1891, the Supreme Court decreed that:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891); *see also* Justice Benjamin Cardozo's opinion in *Schloendorff v. Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body").

The venerable Justice Louis Brandeis echoed this principle nearly four decades later *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) ("[t]he makers of our Constitution undertook to secure conditions favorable to the pursuit of happiness ... [t]hey sought to protect Americans in their beliefs, their thoughts, their emotions and their sensations ... [t]hey conferred ... the right to be let alone -- the most comprehensive of rights and the rights most valued by civilized men").

As Justice O'Connor noted, concurring in *Cruzan*, "[b]ecause our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination, the Court has often deemed state incursions into the body repugnant to the interests protected by the Due Process Clause." 497 U.S. 261, 287. Not only has this Court long-protected an individual's bodily integrity, it also has expressly (a) confirmed the existence of a right (based in Fourteenth Amendment liberty interests) of an individual to make life and death decisions, and (b) recognized the potential for abuse of

that right, acknowledging the need for appropriate state regulation:

> The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe [the state] may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements. In cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment. Not all incompetent patients will have loved ones available to serve as surrogate decisionmakers. And even where family members are present, "there will, of course, be some unfortunate situations in which family members will not act to protect a patient." A State is entitled to guard against potential abuses in such situations.

Cruzan, 497 U.S. 261, 281 (citations omitted).

Most recently, this Court articulated its respect for personal autonomy in making life's most personal decisions:

> It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter. * * * * * These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life.

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 847, 851 (1992) (citations omitted).

There can be no decision in life more personal, more intimate, and more warranting of constitutional protection than that of a terminally-ill patient contemplating whether to live under the burden of disease, pain and indignities, or to accede to mortality when death is at the door. Moreover, this position is hardly unique to ACLM; it underlies each of the federal appellate decisions at issue here:

> In our system of a free government, where notions of individual autonomy and free choice are cherished, it is the individual who must have the final say in respect to decisions regarding his medical treatment in order to insure that the greatest possible protection is accorded his autonomy and freedom from unwanted interference with the furtherance of his own desires.

Quill, 80 F.3d at 727 (citation omitted).

> [T]he decision how and when to die is one of "the most intimate and personal choices a person may make in a lifetime," a choice "central to personal dignity and autonomy." A competent terminally-ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final period of his existence, but in many cases, the enduring memories held by those who love him.

Compassion in Dying, 79 F.3d at 813-814.

Under this weighty precedent, and under the language of the distinguished panels of the Second and Ninth Circuits, ACLM asserts that there is ample foundation on which to recognize and protect the liberty interests of a mentally-

competent adult in the end-stages of a terminal illness to obtain care and treatment intended to end life.

Finally, ACLM recognizes and supports the Second Circuit's decision in *Quill*, which, too, recognizes the constitutional right of "qualified" patients to seek medical treatment intended to end life -- a decision based on equal protection, rather than due process, grounds. The Second Circuit's decision, however, is squarely-premised upon its finding that there is no relevant distinction between the withdrawal or withholding of life-support systems and treatment with the intent to hasten death, on the one hand, and the administration of drugs with the intent to hasten death, on the other hand. While ACLM agrees, believing both acts to be medical treatment intended to end life, ACLM also recognizes that there is room for reasonable debate and disagreement with respect to that distinction. Because the right sought herein is fundamental to those principles of liberty secured under the Fourteenth Amendment, ACLM believes the right should be recognized under the Due Process Clause.

B. ACLM's Position Does Not Infringe Upon The Integrity Of The Medical Profession.

ACLM -- an organization led by and including numerous physicians -- asserts that its position in no way infringes upon the integrity of the medical profession. Those who argue otherwise, most notably the *Compassion in Dying* petitioners and the AMA, contend essentially that a physician is barred from assisting in the termination of life under any conditions due to his or her obligations imposed by the Hippocratic Oath. The Ninth Circuit cleanly disposed of this contention. Noting that the identical argument was asserted in *Roe v. Wade* and *Cruzan*, in opposition to the rights sought in those cases, the Ninth Circuit stated that the Oath was not even accepted by all physicians at the time it was created. 79 F.3d at 829. Moreover, the Oath hardly "represent[s] the best or final word

on medical or legal controversies today." *Id.* Finally, to impose upon American jurisprudence the dictates of the Oath would, arguably, not only preclude a physician, in all situations, from performing an abortion, from terminating life-support and from providing treatment intended to end life, it would furthermore preclude a physician from engaging in surgery. *Id.* Clearly, American law should not rely upon the Hippocratic Oath in constitutional interpretation.

Finally, ACLM fully acknowledges and supports an individual physician's right to decide whether to provide care and treatment intended to end life. The physician who finds religious, moral or ethical reasons not to provide such treatment certainly need not do so. ACLM asserts, however, that, as shown in *Roe* and *Cruzan*, this option of the individual physician should not bar "qualified" patients from exercising a constitutional right to seek such treatment.

C. The Treatment At Issue Here Is Consistent With Treatment Long-Provided By Physicians.

In *Compassion in Dying*, the State of Washington argued to the Ninth Circuit that it was appropriate to draw a distinction between, on the one hand, a physician prescribing medication for the *sole purpose* of hastening death -- behavior, the state argued, is and should be criminalized -- and on the other hand, a physician prescribing medication for the *dual purposes* of alleviating pain and hastening death -- behavior, the state argued, is appropriate and lawful. 79 F.3d at 823.

In this regard, ACLM confirms the Ninth Circuit's understanding that, for decades, physicians have routinely and openly provided medication to terminally-ill patients with the knowledge that the drug will have the dual effect of reducing pain and hastening death. 79 F.3d at 823. If, however, this practice is to remain lawful, as the State of Washington and the AMA argue it should, then it is wholly inconsistent to argue that "sole purpose" treatment must remain unlawful. It

defies logic to contend that the physician, who prescribes a drug that will alleviate pain and hasten death, is a merciful healer, while the physician, who prescribes a drug that will hasten death and thereby eliminate pain, is a punishable felon. *See also* 79 F.3d at 823 n. 95. Under common medical practice of the day, this inconsistent result would be realized by upholding the subject statutes in their entirety.

IV. Conclusion

ACLM began this brief with the words of Seneca uttered over twenty centuries ago. His words are prophetic and instructive, because he contemplates the instinctive zest for meaningful life, while acknowledging the pointless despair resulting from physical deterioration. Indeed, risks exist in recognizing the right of competent adults in the end-stages of a terminal illness to determine the time and manner of their death; but safeguards, crafted and imposed by government and by the healthcare community, will minimize the threat of abuse and assuage societal fears. With appropriate protocols, we must take and overcome these calculated risks to secure human dignity and personal autonomy in death. Sherwin B. Nuland, M.D., in his book, *How We Die* (Vintage 1995), ties this notion to the words of Seneca:

> All of this is not to say that there are no situations in which Seneca's words deserve heeding. But should this be so, the Roman's doctrine would then deserve consultation, counsel, and the leavening influence of a long period of mature thought. A decision to end life must be as defensible to those whose respect we seek as it is to ourselves. Only when that criterion has been satisfied should anyone consider the finality of death.

Nuland at 152. Criteria and protocols are, indeed, the watchwords of the day.

Moreover, ACLM is mindful of the vast benefits of advancements in medicine and technology; but science not only prolongs life, it concomitantly prolongs misery, pain and suffering. With this in mind, we ought not be driven by medical advancement to the disregard for the rights of terminally-ill patients, such as those on whose behalf the instant cases were brought. ACLM recommends to this Court the Nuland book (*supra*), and especially the story of the final days, in 1961, in the life of Harvard Physicist and Nobel Laureate, Professor Percy Bridgman. A colleague remembers Bridgman, then suffering from terminal cancer, deploring the need to end his own without assistance:

> I would like to take advantage of the situation in which I find myself to establish a general principle: namely, that when the ultimate end is as inevitable as it now appears to be, the individual has a right to ask his doctor to end it for him.

Nuland at 152-153. The message Seneca conveys and the words of Professor Bridgman, though separated by over 2000 years, are very much alike. The similarity shows a constancy in the human spirit and the quest for autonomy and dignity, existing long before and lasting long after our founding fathers incorporated this notion of liberty into the Constitution.

The cases before this Court involve, first and foremost, particular patients and their sacrosanct relationship with their caregivers. That that relationship serves the best interests of a patient, as well as society, is perhaps evidenced best by the graphic and compelling description of the death of an AIDS patient as recounted by his physician, one of the plaintiff physicians in *Compassion in Dying*:

> One patient of mine ... lingered in the hospital for weeks, his lower body so swollen from oozing Kaposi's lesions that he could not walk, his genitals so swollen that he required a catheter to drain his bladder, his fingers gangrenous from clotted arteries. ... [F]riends stopped visiting him because it gave them nightmares. [The patient's] agonies could not be relieved by medication or by the excellent care he received. [He] begged for assistance in hastening his death. As his treating doctor, it was my professional opinion that [the patient] was mentally competent to make a choice with respect to shortening his period of suffering before inevitable death. I felt that I should accommodate his request. However, because of the [State of Washington] statute, I was unable to assist him and he died after having been tortured for weeks by the end phase of his disease.

79 F.3d at 814. **American jurisprudence should not countenance suffering of this nature; an individual's Fourteenth Amendment liberty-rights do not allow for it.**

"Contemporary times demand contemporary, thoughtful and humane responses to the critical issue of terminally ill patients, not lock-step repetition of past follies." Smith, *supra* at 355. ACLM proposes such a contemporary, thoughtful and humane response.

Respectfully submitted,

AMERICAN COLLEGE OF LEGAL MEDICINE

By: _____

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APPENDIX A

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October 18, 1996

Mr. Miles J. Zaremski
Rudnick & Wolfe
102 North LaSalle Street Suite 1800
Chicago, Illinois 60601-1293

Re: *Washington v. Glucksberg*,
U.S. Supreme Court Cause No. 96-110

Dear Mr. Zaremski:

This responds to your letter of October 14, 1996, requesting consent to file a brief as *amicus curiae* in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Very truly yours,

WILLIAM L. WILLIAMS
Sr. Assistant Attorney General

WLW:am

cc: Kari A. Smith

CONSENT TO FILING BRIEF *AMICUS CURIAE*

No. 95-1858

IN THE SUPREME COURT OF
THE UNITED STATES

October Term, 1995

DENNIS C. VACCO, Attorney General of the State of New York;
GEORGE E. PATAKI, Governor of the State of New York; and
ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.;
and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

Consent to File Brief *Amicus Curiae*

Miles J. Zaremski, Esq.
Rudnick & Wolfe
203 North LaSalle St., Suite 1800
Chicago, Illinois 60601-1293

Pursuant to Rule 37, Petitioners Dennis C. Vacco, Attorney General of the State of New York, and George E. Pataki, Governor of the State of New York, hereby consent to the filing in this matter on behalf of the American College of Legal Medicine of a brief amicus curiae.

Barbara G. Billet
Solicitor General
State of New York
Office of the Attorney General
120 Broadway
New York, New York 10271

APPENDIX A-2

ROBERT M. MORGENTHAU
District Attorney

DISTRICT ATTORNEY
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(212) 335-9000

October 17, 1996

Miles J. Zaremski
Rudnick & Wolfe
203 North LaSalle St. Suite 1800
Chicago, IL 60601-1293

Re: Vacco v. Quill
No. 95-1858

Dear Mr. Zaremski:

Pursuant to my conversation with Lucia M. Valente, Chief Special Counsel to the Attorney General of the State of New York, this confirms that District Attorney Robert M. Morgenthau consents to the appearance of the "American College of Legal Medicine" in the above matter as an amicus curiae under Rule 37.3(a). If you require such consent in a different form please so advise.

Respectfully,

Robert M. Morgenthau
District Attorney
New York County
One Hogan Place
New York, New York 10013
(212) 335-9000

By: Marc Frazier Scholl
Assistant District Attorney
Of counsel
(212) 335-9324

APPENDIX A-3

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October 18, 1996

Miles J. Zaremski
Rudnick & Wolfe
203 North LaSalle Street
Suite 1800
Chicago, IL 60601-1293

Re: *State of Washington v. Glucksberg*, No. 96-110; Amicus Participation

Dear Mr. Zaremski:

This letter replaces the consent letter sent to you on October 16, 1996.

This responds to your letter of October 14, 1996 requesting consent to file a brief as amicus curiae in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Respectfully,

Kathryn L. Tucker

KAS:rak

cc: William L. Williams

APPENDIX A-4

[09901-7505/SL962900.200]

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October 18, 1996

Miles J. Zaremski
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203 North LaSalle Street
Suite 1800
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Re: *Vacco v. Quill*, No. 95-1858; Amicus Participation

Dear Mr. Zaremski:

This letter replaces the consent letter sent to you on October 16, 1996.

This responds to your letter of October 14, 1996 requesting consent to file a brief as amicus curiae in the above-referenced matter on behalf of the American College of Legal Medicine. Your request for consent is granted.

Respectfully,

Kathryn L. Tucker

KAS:rak

cc: Lucia M. Valente, Esq.

APPENDIX A-5

[09901-7505/SL962900.200]

ANCHORAGE BELLEVUE HONG KONG LONDON LOS ANGELES OLYMPIA PORTLAND SEATTLE SPOKANE TAIPEI WASHINGTON, D.C.
STRATEGIC ALLIANCE: RUSSELL & DuMOULIN, VANCOUVER, CANADA

APPENDIX B

March 1996

State Statutes Governing Living Wills and Appointment of Health Care Agents



Jurisdictions with legislation that authorizes both living wills and the appointment of a health care agent (**the District of Columbia and 45 states: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming**).

States with legislation that authorizes only living wills (**2 states: Alabama and Alaska**).

States with legislation that authorizes only the appointment of a health care agent (**3 states: Massachusetts, Michigan and New York**).

Note: The specifics of living will and health care agent legislation vary greatly from state to state. In addition, many states also have court-made law that affects residents' rights. For information about specific state laws, please contact Choice In Dying.

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APPENDIX B-1

APPENDIX C

AMERICAN HOSPITAL ASSOCIATION

Policy and Statement

PATIENT'S CHOICE OF TREATMENT OPTIONS

POLICY

Health care decision making should be based on a collaborative relationship between the patient and the physician and/or other health care professionals who are primarily responsible for the patient's care.* The collaborative framework encourages communciation, which contributes to sound decision making. Whenever possible, however, the authority to determine the course of treatment, if any, should rest with the patient, who may choose to delegate it. In the hospital setting, institutional methods should be established to reasonably assure that the patient may exercise this authority on the basis of relevant information necessary to make a sufficiently voluntary and informed decision. In addition, the health care institution should have methods to identify

*The term *physician* is used throughout the document, although other health care professionals may be responsible for or authorized to provide patient care.

This policy and statement was developed by the Special Committee on Biomedical Ethics, which had been established by the General Council in January 1983 to consider various aspects of biomedical ethical issues facing the health care field.

This document replaces the *Guidelines on the Right of the Patient to Refuse Treatment* that was approved in 1973. The House of Delegates approved the policy and statement in February 1985.

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circumstances under which the patient's authority may be constrained, and recourse to the judgment of others, including the courts, is appropriate.

STATEMENT

The right and responsibility to select among treatment options** presumes that the patient is capable of consulting with the physician about and understanding the available treatment alternatives and their implications and making a choice. Consultation might also take place with other responsible or authorized health care professionals involved in coordinating the patient's care. This process requires the patient's adequately-informed consent and may involve an evaluation of the patient's capacity to make a decision.

Collaborative Decision-Making

Informed consent should reflect shared or collaborative decision making by the patient and the physician. The physician should provide information on the patient's condition, the recommended procedure and/or treatment with its significant benefits and risks, the significant alternative for care or treatment (including no specific treatment), and the likely duration of incapacitation, if any.† Because patient's understanding of this information is essential to informed consent, care should be taken to present it in language familiar to them. Although institutional policy should promote documentation of consent decisions, such documentation is evidence of but not a substitute for communication and understanding between patient and physician. Unless the physician believes the patient would object, it may be advisable and

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**For the purpose of this document, treatment can be interpreted to include diagnostic as well as therapeutic procedures.

†See the AHA Policy on *A Patient's Bill of Rights.*

useful if this information is shared with the patient's family, which often is a valuable resource for both the patient and the physician. Health care institutions and professionals should see to it that patients have access to understandable information relevant to the treatment choices before them.

In cases where the patient has chosen to delegate the treatment choice selection to the physician or someone else, a discussion with the patient about the implications and ramifications of the treatment course to be pursued is still recommended. Often family and friends should be included in this discussion.

In some emergencies, obtaining voluntary and adequately informed consent may not be possible or may be detrimental to the patient's well-being. In such cases, the patient's consent to the course of treatment chosen by a physician may be legally implied from the urgent circumstances surrounding the provision of that care.

Implications of Treatment Choice

The right to choose treatment includes the right to refuse a specific treatment or all treatment, or select an alternative form of treatment. If the patient decides to refuse all treatment, a written informed refusal is strongly recommended to protect the hospital, the physicians, and all other personnel from liability, if any, for failure to furnish treatment. This decision should also be documented on the patient's chart.

If a patient chooses a course of treatment that is not acceptable to the attending physicians or other health care professionals, those individuals may withdraw from the case, so long as doing so does not amount to legal abandonment. If a suitably qualified alternative physician or health care professional willing to comply with the patient's preference is available, transfer to the care of that individual should be offered to the patient. If no physician or qualified health care

professional is willing to undertake the patient's choice of treatment, the hospital should have a policy to address what procedures relative to care of the patient should be followed. The hospital also should have a policy to help identify and address those situations when the course of treatment selected is unacceptable to the mission of the institution.

Laws regarding the right of a patient or someone on the patient's behalf to refuse treatment vary from state to state. Some state laws limit a patient's right to refuse treatment, and others make provisions to facilitate the exercise of this right. The hospital's and the physician's response to a refusal, whether action or nonaction, must be consistent with applicable law. If a refusal can potentially result in substantial detriment to the patient's health and well-being, institutions should require that the appropriate administrative authority be informed. Protection of the patient's authority to select treatment at times may require either legal counsel or judicial proceedings.

Decision-Making Capacity

Decision-making capacity is the ability to make choices that reflect an understanding and appreciation of the nature and consequences of one's actions. Attention should be paid to the difference between decision-making capacity and legal competency. Decision-making capacity may exist, as in the case of a minor, where no legal competency exists. Legal competency may exist where decision-making capacity does not, as in the case of a temporarily impaired adult who has not been deemed legally incompetent. In health care treatment decisions, decision-making capacity is best understood as the patient's ability to understand the nature and effects of treatment options, and appreciate the impact of a choice. Only when the patient's capacity to make decisions is definitely impaired and the effect of flawed decision making

is potentially serious should the patient's right and responsibility for decision making be transferred to others.

When there is reason to doubt the usual presumption of adequate decision-making capacity, an assessment of capacity is made by the physician in consultation with the family, friends, nurses, and other health care professionals. The institution should have effective policies to facilitate assessment of patients' decision-making capacity. The institution should have methods to ensure that the physician conducts these assessments when necessary. The hospital should also see to it that there are accessible and practical avenues by which concerns about a patient's capacity to make decisions may be raised by others, including family, friends, nurses, and other health care professionals. The hospital may also wish to have a policy under which a patient, in appropriate circumstances, should be informed both of any concerns raised by the assessment and of access to procedures for reassessment or to legal counsel. Only when the determination regarding decision-making capacity is controversial among concerned persons (including the patient) should legal guardianship proceedings be required.

When a patient lacks adequate decision-making capacity, substantial effort should be made to ensure that the choice of medical treatment is consistent with the known views of the patient. The decision makers must seek and take note of any information reflected in oral statements, life-style commitments, living wills, and so forth made by the patient before deterioration of decision-making capacity. These known views can sometimes be supplied by the family or an individual acting as surrogate. The surrogate should be a person or group of persons most likely to be able to advocate on the patient's behalf and to assess the patient's preferences and experiences. If the physician knows through informal communications, durable power of attorney, or living will of the patient's designation of a surrogate, that person should serve unless mitigating factors are apparent.

If the selection of the surrogate seems controversial, methods for institutional review and, if necessary, court adjudication are required. In some cases, court appointment of a surrogate may be legally required. The institution should be prepared to refer difficult cases to court for guardianship determinations.

Role of Minors in Decision-Making

Patients who are minors should be allowed to participate in decision-making about their care to the extent possible with regard to their capacity to understand treatment options and outcomes. When a minor is deemed legally incapable of making a decision, that is, not considered to be a "mature" or "emancipated" minor according to state law, the parent or legal guardian usually will have the final decision-making authority. Mature or emancipated minors, as determined by state law, should be treated as adults with decision-making capacity.

Institutions should establish policies concerning the circumstances under which legal advice is to be sought for either the institution or the minor, including cases where a parent or guardian makes a decision that may be deemed adverse to the interests of a minor or opposed to the expressed views of a relatively mature minor.

Management Practices and Procedures

Hospitals have a responsibility to assess the effect of management practices and procedures on patient decision-making options and to foster awareness among health care professionals and key hospital personnel that some institutional practices necessary to ensure efficiency, such as some admissions or food service procedures, can unintentionally limit patient choices. For example, the patient often does not have the opportunity to make many of the routine choices in day-to-day living–when to have meals, wake up, have visitors, etc.

Documentation of Decision-Making

Documentation of decisions regarding patient treatment promotes orderly procedures and more thorough consideration of options. Documentation also provides legal protection for and is often in the best interests of patients, patients' families, concerned health professionals, and hospitals.

Conclusion

The patients' role in determing the course of their medical treatment must be ensured in the institutional setting. Although these decisions should be made in collaboration with the attending physicians, the hospital must take a leadership role in ensuring institutional practices that support patients' decision making and in identifying when recourse to the judgment of others is necessary.

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No. 95-1858 and No. 96-110

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On Appeal from the United States Courts of Appeals for the Second Circuit and Ninth Circuit

BRIEF FOR BIOETHICS PROFESSORS AMICUS CURIAE SUPPORTING PETITIONERS

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QUESTIONS PRESENTED

Is there a difference between the constitutional right of a competent adult to refuse medical treatment, including life-sustaining medical treatment, and the right of a competent, terminally ill adult to have a physician prescribe lethal medication for the purpose of committing suicide?

Does the constitutional right of a pregnant woman to terminate a pregnancy by a physician-performed or prescribed medical procedure support a constitutional right of a competent, terminally ill adult to have a physician prescribe lethal medication for the purpose of committing suicide?

TABLE OF CONTENTS

Page

Interest of Amicus 1

Summary of Argument 2

Argument 3

I. The Right of a Competent Individual to Refuse Medical Treatment is Universally Recognized, is Deeply Rooted in the History and Traditions of the United States, and has Never before been Equated with Suicide by an Appeals Court or State Legislature. 3

A. The Right of a Competent Individual to Refuse Medical Treatment is Universally Recognized and Deeply Rooted in the History and Traditions of the United States. 3

B. The Right to Refuse Treatment has Never been Equated with Suicide by an Appeals Court or State Legislature and is Unrelated to any Purported Right to Physician Assisted Suicide... 10

II. The Constitutional Right of Pregnant Women to Terminate a Pregnancy is Based on Facts and Constitutional Principles that do not Encompass any Asserted Constitutional Right to Physician Assistance in Suicide. 21

A. The Constitutional Right of a Pregnant Woman to Terminate a Pregnancy is based on her Interest in her own Life, Health, and Future. 21

B. Unlike Other Aspects of Personal Life that have been Protected from State Interference by the Constitutional Right of Privacy or Personal Liberty, the Right to Physician Assisted Suicide is Poorly Defined and its Exercise Cannot be Limited by Logic or Principle. 23

C. Any Purported Constitutional Right to Physician Assistance in Suicide does not follow from a Woman's Right to Terminate a Pregnancy because 26

Page

1. Assistance in Suicide is not a Medical Procedure. 26
2. Regulating Physician Assisted Suicide would require Intrusions into the Physician-Patient Relationship that have been Rejected as Unconstitutional in Implementing a Woman's Decision to Terminate a Pregnancy. 28

Conclusion 30

Appendix: Bioethics Professors

TABLE OF AUTHORITIES

Cases: Page

In re A.C., 573 A.2d 1235 (D.C. App. 1990) 12

Bartling v. *Superior Court*, 163 Cal.App.3d 186, 209 Cal. Rptr. 220 (2d Dist. 1984) 6, 12

In re Brooks' Estate, 32 I11.2d 361, 205 N.E.2d 435 (1965) 9

Canterbury v. *Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) 5

Carey v. *Population Services*, 431 U.S. 678 (1977) ... 23

Cobbs v. *Grant*, 8 Cal.3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) 5

Matter of Colyer, 99 Wash.2d 114, 660 P.2d 738 (1983) 12

Communications Workers of America v. Beck, 487 U.S. 735 (1988) 16

Compassion in Dying v. *Washington*, 79 F.3d 790 (9th Cir 1996) ..... 3, *passim*

In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) 11, 17

Cruzan v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) 7, 17

Doe v. *Bolton*, 410 U.S. 179 (1973) 29

Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 23

Erickson v. *Dilgard*, 44 Misc.2d 27, 252 N.Y.S.2d 705 (1962) 9

Fosmire v. *Nicoleau*, 75 N.Y.2d 218, 551 N.E.2d 77, 551 N.Y.S.2d 876 (1990) 12

Greene v. *Edwards*, 164 W.Va. 326, 263 S.E.2d 661 (1980) 7

Griswold v. *Connecticut*, 381 U.S. 479 (1965) 23

Jacobson v. *Massachusetts*, 197 U.S. 11 (1905) 6

Jefferson v. *Griffin Spalding Co. Hospital Authority*, 247 Ga. 86,274 S.E.2d 457 (1981) 12

JFK Memorial Hospital v. *Heston*, 58 N.J. 576, 279 A.2d 670 (1971) 10

Lane v. *Candura*, 6 Mass.App.Ct. 377, 376 N.E.2d 1232 (1978) 5

	Page
Loving v. *Virginia*, 388 U.S. 1 (1967)	23
Matter of Melideo, 88 Misc.2d 974, 390 N.Y.S.2d 523 (1976)	9
Norwood Hospital v. *Munoz*, 409 Mass. 116, 564 N.E.2d 1017 (1991)	12
In re Osborne, 294 A.2d 372 (D.C.App. 1972)	9
Palko v. *Connecticut*, 302 U.S. 319 (1937)	22
Pierce v. *Society of Sisters*, 268 U.S. 510 (1925)	23
Planned Parenthood of Southeastern Pennsylvania v. *Casey*, 502 U.S. 1056 (1992)	21
Pratt v. *Davis*, 118 Ill.App.161 (1905), *aff'd* 224 Ill. 300, 79 N.E. 562 (1906)	5
Application of the President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C.Cir. 1964)	8, 10
In re Quackenbush, 156 N.J.Super. 282, 383 A.2d 785 (1978)	5
Quill v. *Vacco*, 80 F.3d 716 (2d Cir. 1996)	4, *passim*
In re Quinlan, 70 N.J. 10, 355 A.2d 647 (1976)	11, 13
Roe v. *Wade*, 410 U.S. 113 (1973)	23, 26
Satz v. *Perlmutter*, 362 So.2d 160 (Fla.Dist.Ct.App. 4th Dist. 1978)	4, 12
Schloendorff v. *Society of New York Hospital*, 211 N.Y. 125, 105 N.E.2d 92 (1914)	5
Stanley v. *Georgia*, 394 U.S. 557 (1969)	23
In re Storar, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266 (1981)	13
Superintendent of Belchertown v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977)	12, 13
United States v. *George*, 239 F.Supp.752 (D.Conn. 1965)	8
Washington v. *Harper*, 494 U.S. 210 (1990)	7

Statutes:

Or. Rev. Stat. §127.800 et seq. (1995)	29

Miscellaneous:

	Page
Alesandro, Comment, *Physician Assisted Suicide and New York Law*, 57 ALB. L. REV. 820 (1994)	15
Annas, STANDARD OF CARE (1993)	12
Annas, *Physician Assisted Suicide - Michigan's Temporary Solution*, 20 OHIO.U.L. REV. 561 (1994)	27
Callahan & White, *The Legislation of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. RICH. L. REV. 1 (1996)	29
Harris, A SACRED TRUST (1966)	4
THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 147 (1994)	7
PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL BEHAVORIAL RESEARCH, DECIDING TO FOREGO LIFE SUSTAINING TREATMENT 82 (1983)	19
Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991)	15
Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L.REV. 348 (1986)	16

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BRIEF FOR BIOETHICS PROFESSORS AMICUS CURIAE SUPPORTING PETITIONERS

Interest of Amicus

Amicus is an ad hoc group of 50 professors who teach medical ethics to medical students and/or physicians in universities, medical schools, and clinical settings. The Amicus professors include philosophers, theologians, attorneys, and physicians of different religious backgrounds who have a major professional interest in medical ethics. The Amicus group strongly believes that permitting competent adults to refuse any medical treat-

ment is a fundamental right consistent with medical ethics, is independent of any purported right to physician assisted suicide, and should continue to be protected by the Court. The Amicus group also strongly believes that a woman's constitutional right to decisionmaking regarding abortion in the privacy of the physician-patient relationship should continue to be protected independent of any purported right to physician assisted suicide. Amicus has obtained the written consent of the parties in both actions to filing this brief. (Letters confirming the parties' consent have been filed with the Clerk of the Court.)

Summary of Argument

I

The analytical basis for both the Ninth and Second Circuit Courts of Appeals opinions is that there is no difference between the right of all competent people to refuse recommended medical treatment and the right to physician assisted suicide. There are, however, major differences between the right to refuse medical treatment and the right to physician assisted suicide. The right to refuse treatment is rooted in the history and traditions of this country. It is the expression of the venerable and universally recognized right of all individuals to be free from unwanted and nonconsensual physical invasions of their bodies. All courts that have decided the issue until now have readily distinguished between suicide and refusing treatment, and have permitted the refusal of medical treatment while still recognizing the state's interest in the prevention of suicide.

For these reasons the Court can refuse to recognize a constitutional right to physician assisted suicide and still recognize both constitutional and common law rights to refuse treatment.

II

The Ninth Circuit Court of Appeals' decision derived the

right to physician assisted suicide from the Court's cases that recognize a woman's constitutional right to decide whether or not to terminate her pregnancy. This is mistaken because those cases are specifically directed at enabling a woman to make choices she believes further her health and continued participation in society, whereas assisted suicide leads only to death.

If it is true that people have the constitutional right to commit suicide and, therefore, the constitutional right to assistance in their suicide, there is no reason why this right is limited to assistance from physicians. Unlike abortion, neither suicide nor assisted suicide is a medical procedure.

There is no basis in logic or constitutional law to limit the right to assisted suicide to terminally ill patients. There is no accepted definition of terminal illness, and it is difficult, if not impossible, for physicians to accurately predict any particular individual's life expectancy.

For these reasons the Court can refuse to recognize a constitutional right to physician assisted suicide and still recognize a woman's constitutional right to decide whether or not to terminate a pregnancy.

Argument

I. THE RIGHT OF A COMPETENT INDIVIDUAL TO REFUSE MEDICAL TREATMENT IS UNIVERSALLY RECOGNIZED, IS DEEPLY ROOTED IN THE HISTORY AND TRADITIONS OF THE UNITED STATES AND HAS NEVER BEFORE BEEN EQUATED WITH SUICIDE BY AN APPEALS COURT OR A LEGISLATURE.

A. *The Right of a Competent Individual to Refuse Medical Treatment is Universally Recognized and Deeply Rooted in the History and Traditions of the United States.*

The major premise upon which both the Ninth Circuit Court of Appeals in *Compassion in Dying* v. *Washington*, 79

F.3d 790 (9th Cir. 1996), and the Second Circuit Court of Appeals in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996), rely to find that there is a constitutional right to physician assisted suicide is that there is no rational distinction between physician assisted suicide and the right of an individual to refuse life-saving medical treatment. This premise is not only incorrect, but threatens the well established right to refuse treatment.

The Ninth Circuit Court of Appeals mistakenly believes that the right of individuals to refuse treatment is a modern invention that was only recently bestowed upon individuals by the courts. It states, "The first major breakthrough occurred when the terminally ill were permitted to reject medical treatment." 79 F.3d at 821, citing *Satz* v. *Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *aff'd*, 379 So. 2d 359 (Fla. 1980). The Ninth Circuit Court of Appeals refers to the recognition of the rights of individuals both to refuse and to terminate medical treatment, as "drastic changes regarding acceptable medical practice. . . ." 79 F.3d at 822. To reach this conclusion, the court must have believed that until the 1970's the law permitted patients to be forcibly treated. This demonstrates a profound misunderstanding of the source and application of the right to refuse treatment. It was not until 1912 "when for the first time in human history . . . a random patient with a random disease consulting a doctor chosen at random stood a better than 50-50 chance of benefiting from the encounter." RICHARD HARRIS, A SACRED TRUST 5 (1966). Since medicine had little effective treatment to offer prior to this century, there was no reason to ever attempt to force treatment on patients. When the consent issue did come before courts, their decisions were clear. In 1905, for example, an Illinois court held:

> Under a free government at least, the free citizen's first and greatest right which underlies all others — the right to the inviolability of his person, in other words, his right to himself — is the subject of universal acquiescence, and

> this right necessarily forbids a physician . . . to violate, without permission, the bodily integrity of the patient by a major or capital operation.

Pratt v. *Davis*, 118 Ill. App. 161 (1905), *aff'd* 224 Ill. 300, 79 N.E. 562 (1906).

Similarly, in a 1914 New York case, Justice Brandeis wrote, "every human being of adult years and sound mind has a right to determine what shall be done with his own body. . . ." *Schloendorff* v. *Society of New York Hospital*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

The principles of bodily integrity and self-determination are so basic that they seem to need no justification. Nothing empowers the state to require a free living, competent adult to always comply with medical advice. Such a rule would convert medical advice into medical tyranny. One searches in vain to find a case in which free living competent adults are restrained against their will and forced to submit to treatment by physicians. The law is entirely in the other direction — competent adults are under no legal obligation to submit to offered treatment. The laws of battery and informed consent are barriers against unwanted treatment. *Cobbs* v. *Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); *Canterbury* v. *Spence*, 464 F.2d 772 (D.C. Cir. 1972), *cert. denied* 409 U.S. 1064 (1972).

The case law throughout the United States is consistent and unequivocal: competent adults have the right to refuse any medical treatment, and the exercise of this right is not contingent on suffering from a terminal illness. In *In re Quackenbush*, 156 N.J. Super. 282, 383 A.2d 785 (1978), for example, a 72-year-old man refused to have his gangrenous legs amputated. He was not terminally ill or comatose. He could live indefinitely if he submitted to the recommended treatment but would soon die if he refused the treatment. The court found that this competent man could refuse such life saving treatment. Similarly, in *Lane* v. *Candura*, 6 Mass. App. Ct. 373, 376 N.E.2d 1232 (1978), the Massachusetts appeals court

found that a competent 77-year-old woman could refuse a life-saving amputation of her foot. She was not terminally ill and could live indefinitely if the procedure were performed. As the court concluded, "we are all of the opinion that the operation may not be forced upon her against her will." 6 Mass. App. Ct. at 384, 376 N.E.2d at 1236.

Failure to honor this right leads to horrific consequences. William Bartling, a 70-year-old man who was suffering from five potentially fatal illnesses, was so insistent on refusing treatment that he had removed his ventilator himself on several occasions. In response, the physicians ordered his hands tied to his bed. The trial judge ruled that his ventilator could not be removed because Mr. Bartling was not terminally ill, comatose, or brain dead. Since none of these conditions are prerequisites for treatment refusal, the California Court of Appeals reversed. It ruled that a competent adult could refuse any treatment, including life-sustaining treatment, and that the act of removing a ventilator at the patient's demand was no different legally from not attaching a ventilator in the first place. *Bartling* v. *Superior Court*, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (2d Dist. 1984). No competent person should ever be forcibly treated in this country, and appellate courts have consistently confirmed this principle.

The principle of consent with its complementary right to refuse and withdraw consent is fundamental. How could it be otherwise? What power could be called upon that would permit the state to forcibly amputate the limbs of competent people? Certainly the *parens patriae* power does not apply to competent people, and the police power does not apply where the person's decision only affects him- or herself.[1] Absent

[1] There is no doubt that the state, in the exercise of its police powers, has the authority to limit the exercise of an individual's autonomy for the purpose of protecting the public's health. *See, Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). But even in that case, the Court did not rule that Jacobson could be forcibly vaccinated. Rather it held that he could be fined for failure to comply with the city's mandatory vaccination order. Those who suffer from contagious diseases, such as tuberculosis, and who refuse treatment that would render them noninfectious can be isolated from the general population. *Greene* v. *Edwards*, 164 W.Va. 326, 263 S.E.2d 661 (1980).

the right to refuse medical treatment, all persons would be required to submit themselves to any treatment a physician recommends. It is estimated that approximately 70 percent of the deaths in hospitals today follow some decision to withhold or to stop treatment. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, WHEN DEATH IS SOUGHT: ASSISTED SUICIDE AND EUTHANASIA IN THE MEDICAL CONTEXT 147 (1994). In an era in which most people die in hospitals or nursing homes, this opens the possibility of all patients being forcibly subjected to an unlimited onslaught of medical interventions at the end of life. Nothing in American law permits this absent patient consent.

This Court has recognized the individual's strong interest in avoiding unwanted treatment. The Court noted, "The *forcible injection of medication* into a nonconsenting person's body represents a substantial interference with that person's liberty." *Washington* v. *Harper*, 494 U.S. 210 (1990) (emphasis added). In *Cruzan* the Court stated "The principle that a competent person has a constitutionally protected liberty interest in refusing *unwanted medical treatment* may be inferred from our prior decisions." *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), 497 U.S. at 278 (emphasis added). Justice O'Connor, in her concurring opinion, said, "Requiring a competent adult to endure *such procedures against her will* burdens the patient's liberty, dignity and freedom to determine the course of her own treatment." 497 U.S. at 289 (emphasis added).

The belief of both Circuit courts that there was a time in American law when a competent individual could not refuse medical treatment may come from a misreading of a few cases from the 1960s that involved Jehovah's Witnesses who refused blood transfusion as a result of their religious beliefs. The patients involved were not terminally ill and would likely

recover and live long, healthy lives if this relatively minor physical intrusion was allowed.

Perhaps the most widely cited of these cases is *Application of the President and Directors of Georgetown College*, 331 F.2d 1000 (D.C. Cir. 1964). In this case, a 25-year-old woman was brought to the hospital with a bleeding ulcer, having lost two-thirds of her blood. Both the patient and her husband were Jehovah's Witnesses. The judge spoke to the husband, and wrote, "He advised me that on religious grounds he would not approve a blood transfusion for his wife. He said, however, that if the court ordered the transfusion, the responsibility was not his." When the judge went to the patient's room he found that "It was obvious that the woman was not in a mental condition to make a decision." The judge asked her if she would oppose a transfusion if he authorized it and reported, "She indicated, as best I could make out, that it would not then be her responsibility." The judge then authorized the blood transfusions. This is not a case of *forcible* treatment being inflicted on a competent patient. Rather it is a case in which neither the incompetent patient nor her husband could consent to the blood transfusion because of their religious beliefs, but made it clear to the judge that they did not oppose his authorization of the treatment. The patient and her husband were relieved to have the judge make this decision for them.[2]

United States v. *George*, 239 F.Supp. 752 (D. Conn. 1965),

[2] Although a petition for a rehearing *en banc* was denied for technical reasons, a number of judges expressed the opinion that the single judge who decided this case had no authority to do so, and that if he did have such authority, his decision was wrong. 331 F.2d at 1010. Circuit Judge (later Chief Justice) Burger asks in his opinion, "If the patient has objections to that treatment based on religious conviction, or if he rejects the medical opinion, are the courts empowered to decide for him?" 331 F.2d at 1017. He later answers this question by stating, ". . . there are myriads of problems and troubles which judges are powerless to solve; and this is as it should be. Some matters of essentially private concern and others of enormous public concern, are beyond the reach of judges." 331 F.2d at 1017-18.

is similar. In this case the judge explained that he had no power to *order* the transfusion and that the patient would be free to resist the transfusion by merely putting his hand over the site where the needle would be inserted. The patient responded he would in no way resist the transfusions once the judge signed the order. Again, this is the case of a person who could not affirmatively consent to a transfusion because of his religion, but who did not oppose being treated.

These cases can be compared to *In re Osborne*, 294 A.2d 372 (D.C. App. 1972), in which a 34-year-old father who was seriously injured in an accident refused a life-saving blood transfusion. Mr. Osborne told the judge, "It is between me and Jehovah, not the courts . . . I'm willing to take my chances. My faith is that strong. I wish to live but with no blood transfusions." No transfusion was authorized in this case.[3]

Far from supporting governmental authority to violate the bodily integrity of competent individuals, these cases demonstrate the respect judges have traditionally shown for individual autonomy in regard to the receipt or refusal of medical care. They have enabled those who wish to receive such care to obtain it, and have protected the bodily integrity of those who did not wish to receive the offered care.

The right defined and protected in all the right to refuse treatment cases is the right to be free from unwanted bodily intrusions. It is not the "right to die" or to determine "the time and manner of one's own death" or to "hasten" one's death.

[3] Other cases in which individuals were found to have the right to refuse life-saving blood transfusions include *Matter of Melideo*, 88 Misc. 2d 974, 390 N.Y.S.2d 523 (1976) (23 year old woman could refuse blood transfusion to save her life); *Erickson* v. *Dilgard*, 44 Misc. 2d 27, 252 N.Y.S.2d 705 (1962) (adult patient has the right to refuse a blood transfusion his doctor said was necessary to save his life); *In re Brooks' Estate*, 32 Ill.2d 361, 205 N.E.2d 435 (1965) (patient may refuse blood transfusion where the decision did not affect public health, safety or morals).

B. *The Right to Refuse Treatment has Never been Equated with Suicide by an Appeals Court or State Legislature and is Unrelated to any Purported Right to Physician Assisted Suicide.*

Both the Ninth and Second Circuit Courts of Appeals base their opinions on the finding that there is no difference between the act of refusing life-sustaining treatment and suicide. In this they are both wrong. Nonetheless, even though courts have repeatedly found that refusing treatment is not suicide, there is some language in two judicial opinions that show a confusion between refusing treatment and suicide. In *Georgetown College*, the judge states, with no analysis,

> where attempted suicide is illegal by the common law or statute, a person may not be allowed to refuse necessary medical assistance when death is likely to ensue without it. Only quibbles about the distinction between misfeasance and nonfeasance, or the specific intent necessary to be guilty of attempted suicide, could be raised against this latter conclusion.

331 F.2d at 1008-9.

This statement is startlingly incorrect. First, at the time it was made, neither the common law nor statutes made it a crime to attempt to commit suicide. Second, the distinction between misfeasance and nonfeasance is far from a quibble. Third, the issue of specific intent is a critical element to be guilty of a crime. Fourth, the judge recognized that the patient did not want to die, but rather death would be "an unwanted side effect of a religious scruple." 331 F.2d at 1009. Finally, the judge found that the patient was incompetent. Because she was not capable of making any decision, she could not attempt to commit suicide. Thus, the discussion of attempted suicide is both misinformed and irrelevant given the facts of the case.

The second case that confuses treatment refusal and suicide is strikingly similar in its lack of analysis. In *JFK Memorial*

Hospital v. *Heston*, 58 N.J. 576, 279 A.2d 670 (1971), the New Jersey Supreme Court ordered a blood transfusion for a 22-year-old Jehovah's Witness who was injured in an accident. In its decision the court said, "It seems correct to say there is no constitutional right to choose to die. Attempted suicide was a crime at common law and was held to be a crime [in New Jersey]. It is now denounced as a disorderly persons offense." 58 N.J. at 580, 279 A.2d at 672. Once again there was no analysis, merely an assumption that refusing treatment was the same as attempting suicide. Again the person in question was unconscious and therefore could not attempt suicide.

The courts that have actually analyzed this issue have readily distinguished refusing treatment from suicide. The same court that decided *Heston* later decided *In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976). In that case, referring to *Heston*, the New Jersey Supreme Court wrote, "we would see, however, a real distinction between the self infliction of deadly harm and a self determination against artificial life support or radical surgery. . . ." 70 N.J. at 43, 355 A.2d at 665.

In a later case the New Jersey Supreme Court addressed the issue more directly, saying:

> declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. . . . The difference is between self-infliction or self-destruction and self-determination. To the extent that our decision in *[Heston]* implies the contrary, we now overrule it.

In re Conroy, 98 N.J. 321, 350-51, 486 A.2d 1209, 1224 (1985).

All the courts that have enforced the right to refuse treatment have pointed out that the state may have compelling

interests that would allow it to abridge the exercise of that right. One of the avowed countervailing state interests is the prevention of suicide.[4] However no court has ever prevented a person from refusing treatment on the grounds that it would constitute suicide. Rather, *all* courts since *Quinlan* that have considered the issue distinguish between refusing treatment and attempting suicide. *See, e.g., Superintendent of Belchertown* v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). ("There is no connection between the conduct here at issue [refusing life-saving treatment] and any state concern to prevent suicide"); *Satz* v. *Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 4th Dist. 1978) (removing respirator from competent person would not be suicide but rather death from natural causes); *Bartling* v. *Superior Court*, 163 Cal. App.3d 186, 209 Cal. Rptr. 220 (2d Dist. 1984); *Matter of Colyer*, 99 Wash. 2d 114, 660 P.2d 738 (1983); *Fosmire* v. *Nicoleau*, 75 N.Y.2d 218, 551 N.E. 2d 77, 551 N.Y.S. 2d 876 (1990) ("merely declining medical care, even essential treatment, is not considered a suicidal act").

[4] The other articulated state interests are the preservation of life, the protection of innocent third parties and the protection of the ethical integrity of the medical profession. The state's interest in the preservation of life has not been used to deprive individuals of their right to refuse treatment. Neither has the interest in the integrity of the medical profession been used this way. It had been thought that the interest in the protection of innocent third parties might cause courts to restrict the exercise of this right when the person refusing life saving treatment was the parent of a minor child. It has not been used this way, and courts have upheld the right of people with children to refuse treatment. *e.g, Fosmire* v. *Nicoleau*, 75 N.Y.2d 218, 551 N.E. 2d 77, 551 N.Y.S. 2d 876 (1990); *Norwood Hospital* v. *Munoz*, 409 Mass. 116, 564 N.E.2d 1017 (1991). This interest has been mistakenly used to attempt to prospectively restrict a treatment refusal of a woman during childbirth by one state supreme court. *Jefferson* v. *Griffin Spalding Co. Hospital Authority*, 247 Ga. 86, 274 S.E.2d 457 (1981). A more recent case has properly repudiated the use of force during childbirth as entirely unprincipled. *In re A. C.*, 573 A.2d 1235 (D.C. App. 1990). George J. Annas, Standard of Care 35-46 (1993). Given the regularity with which courts cite these state interests, it is notable that they have not been exercised in practice to limit the right to refuse treatment.

This makes sense when one considers the legal elements of suicide. To commit suicide one must (1) have the specific intent to die, and (2) intentionally set the death producing agent into motion. *Saikewicz*, 370 N.E.2d at 426, n.11. In all the refusing treatment cases the person refusing the treatment did not put the death producing agent into effect; death would be caused by the underlying medical condition which the person did not cause. *None* of the courts that have decided the right to refuse treatment cases have questioned the state's interest in the prevention of suicide. Rather, they all distinguish suicide from treatment refusal. The fact that a treatment refusal leads to death does not mean the patient's refusal of treatment is suicide.[5]

[5] The parties in the right to refuse treatment cases also understood the difference between refusing treatment and suicide. For example, Karen Ann Quinlan was a young woman in a persistent vegetative state, but not terminally ill. Her parents demanded that their daughter's ventilator be discontinued because they believed that is what she would have wanted. The doctors refused. The New Jersey Supreme Court, the country's first to decide a case involving withdrawal of life-sustaining medical technology (sometimes mistakenly called a "right to die" case) agreed that her wishes should be respected, and the ventilator was removed. Neither Ms. Quinlan nor her parents on her behalf, all devout Catholics, ever thought they were involved in suicide. The New Jersey Supreme Court carefully reviewed Catholic doctrine, which adamantly opposes suicide, assisted suicide, and euthanasia, but supports the right to refuse treatment. Pope Pius XII, in his Nov. 24, 1957 *allocutio*, said "that withdrawal or nonuse of mechanical ventilation ... is not to be considered euthanasia in any way; that would never be licit. The interruption of attempts at resuscitation, even when it causes the arrest of circulation, is not more than an indirect cause of the cessation of life; and we must apply in this case the principle of double effect." 70 N.J. at 31, 355 A.2d at 658. *See also* Amicus Curiae Brief of the Medical Society of New Jersey.

Similarly, in a New York case, Brother Joseph Fox, an elderly Catholic brother of the Society of Mary, said to his friend and confessor Father Philip Eichner, before surgery, words to the effect, "If I wind up like Karen Quinlan, pull the plug." *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S. 2d 266 (1981). Since suicide is a mortal sin in the Catholic Church, it is likely that Brother Fox would have been horrified at the notion that his refusal of a ventilator when in a persistent vegetative state (the condition he actually was in after unsuccessful surgery) constituted suicide. Ethics and theology, like the law, recognize the difference between refusing treatment and suicide.

The Second Circuit Court of Appeals holding is based entirely on equal protection analysis, and thus its conclusion is controlled by its finding that there is not even the most minimally rational distinction between refusing treatment and suicide. The Second Circuit Court of Appeals opinion states,

> [I]t seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, *except for the previous attachment of life-sustaining equipment*, are not allowed to hasten death by self administering prescribed drugs.

80 F.3d at 728-9 (emphasis added).

This statement itself demonstrates that these classes of individuals are not similarly situated. One group is on life support, the other group is not. The fact that one group is on life support demonstrates that members of this group are being subjected to an ongoing bodily intrusion. This intrusion could only have taken place with their consent and, just as they could have refused the intrusion, they can withdraw their consent at any time. The circumstance that empowers the person on life-sustaining equipment to refuse further treatment is not the terminal illness, but the now undesired bodily intrusion. One need not be terminally ill to withdraw consent from an intrusion — one need only be intruded upon. Thus the "terminally ill" person *who is not on life support* is differently situated because he or she is not being subjected to an ongoing physical intrusion. Both have the same right to refuse treatment, although, as a practical matter, this right can only be exercised by one who is being treated or for whom treatment is recommended. In terms of the purported right to physician assisted suicide, the person on life support is treated identically to the person not on life support by the law: neither may have their suicide assisted by the provision of a prescription drug by their physicians (assuming that such an act by the physician is illegal at all).[6]

[6] It should be noted that no case has ever held that a physician who prescribes drugs a patient later uses to commit suicide is guilty of assisting suicide. No physician has ever been charged with such an offense. It is surprising that the Ninth Circuit Court of Appeals could simultaneously find that the doctors in Washington run a "severe risk of prosecution," 79 F.3d at 795, and that there is "no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death." 79 F.3d at 811. In its footnote 54, it describes two cases where physicians were charged with directly administering lethal injections to patients. While the court refers to these as assisted suicide cases, they were in fact homicide cases. Both physicians were acquitted.

It is unlikely that the mere prescription of drugs for a patient constitutes assisted suicide. The named plaintiff in the Second Circuit Court of Appeals case, Dr. Timothy Quill, admitted in an article published in a prestigious medical journal that he had prescribed a lethal dose of sleeping pills for a patient so she could decide at some future time whether or not to commit suicide with these pills. Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 NEW ENG. J. MED. 691 (1991). Based on this admission, a Grand Jury investigated the case and refused to indict. Furthermore, the New York Board for Professional Medical Conduct conducted an investigation to determine if Dr. Quill should be disciplined for his actions. The panel found Dr. Quill acted lawfully and appropriately. It noted that he could not determine with certainty what use the patient might make of the drugs he prescribed. Even if Dr. Quill prescribed the drugs believing they might be used by the patient to commit suicide, he did not participate in the taking of her life. The panel did not wish to interfere with the good medical practice of physicians who prescribe drugs to relieve a terminal patient's anxiety, insomnia or pain because the physician suspects the patient may later use the medication to terminate his or her life. *See*, John Alesandro, Comment, *Physician Assisted Suicide and New York Law*, 57 ALB. L. REV. 820, 823 n. 19 and 21 (1994). Thus, in the only case ever investigated that resembles the activities the plaintiffs claim are illegal in New York, the authorities ruled that the actions were lawful.

It must be kept in mind that the activity in question is the prescription of drugs by physicians. Once the prescription is written the patient must decide whether to fill it, and then must decide whether to use the drugs for the lawful purpose for which a prescription is written, such as relief of insomnia, or to take these drugs to commit suicide. These decisions all occur over a lengthy period of time. Thus there is a long and tenuous chain of events between the writing of the prescription and its use for suicidal purposes.

This is quite different from prosecuted assisted suicide cases, where there is a close link between the assistance and the act of suicide. In one case a defendant helped her sister to commit suicide by attaching a vacuum

Both the Second and the Ninth Circuit Courts of Appeals rely heavily on the termination of artificial nutrition and hydration cases to support the proposition that there is no difference between a physician who complies with a patient's right to refuse treatment and a physician who assists suicide. 79 F.3d at 822-823, 80 F.3d at 729. They argue that a person like Nancy Cruzan does not die of her underlying condition but rather of an independent cause, starvation. This is simply incorrect. When a person requires the administration of artifi-

cleaner hose to the end of an exhaust pipe of a car, gave her sister the other end of the hose, said good-bye and closed the garage door as she left. In another case a husband helped his cancer ridden wife commit suicide by preparing an overdose of sedatives, sitting with her while she ate it, and helping her put a plastic bag over her head. Catherine Shaffer, Note, *Criminal Liability for Assisting Suicide*, 86 COLUM. L. REV. 348, 366, n. 77, 79 (1986). In these cases, and others cited in the article, the "assistance" that was found to be unlawful was much more direct than writing prescriptions, much closer in time to the commission of the suicide, and led directly to the suicide. At least three of the six patient-petitioners in these two appeals were not suicidal at the time they signed their declarations, but rather wanted exemptions from the drug laws so that they could have their physicians write them prescriptions for lethal drugs that they *might* use at some time in the future to commit suicide *if* their suffering became intolerable. 79 F.3d 794-5; 80 F.3d 720-21.

It is notable, given the relief sought in this case by the plaintiffs, that no court has actually concluded that writing a prescription constitutes assisting suicide. Perhaps the federal courts should have remanded the issue to the state courts for a definitive interpretation of the statutes in question. Both statutes are written in general terms and neither explicitly forbids physicians from writing prescriptions for their patients. Furthermore, it may have been possible for the federal courts to have interpreted the statutes in a way that would have made it unnecessary for them to decide the constitutional question. *Communications Workers of America* v. *Beck*, 487 U.S. 735, 762 (1988).

Interestingly, the Ninth Circuit opinion states "we are doubtful that deaths resulting from terminally ill patients taking medication prescribed by their doctors should be classified as 'suicide'." This is likely to be correct, and if it is correct then there is no need to resolve whether there is a constitutional right to assistance. If writing a prescription for drugs a patient may or may not use at some unspecified future time to commit suicide does not constitute assisted suicide under state law, then physicians may prescribe such drugs for their terminally ill patients without any constitutional determination by a federal court.

cial forms of nutrition and hydration for his continued existence, this is beacuse, by definition, he suffers from a condition that prevents him from eating and drinking in a normal fashion. In the absence of medical treatment that provides artifical nutrition and hydration, the person would die from the lack of nutrition or hydration which is itself caused by the disease or condition. Thus, terminating artifical nutrition or hydration is no different from terminating any other medical treatment including artifical respiration, kidney dialysis or chemotherapy.[7] Termination of treatment returns the person to the status quo prior to the bodily intrusion. Subsequently, in the absence of these intrusions, the disease takes its course.

This is in stark contrast to assisted suicide. In such a case the person dies from a cause entirely external to the disease or condition from which the person suffers. If a person has cancer or AIDS, the person will not die from a barbiturate overdose, potassium chloride poisoning, or carbon monoxide poisoning unless these foreign substances are introduced into the person's body. If the substances are introduced, then death would be caused by poisoning, and not by the disease process taking its course.

The failure to distinguish real causes of death from the medical tools and techniques that may temporarily substitute for particular bodily functions is fatal to the logic of both of these opinions. If one were to accept that Nancy Cruzan "died of

[7] "Artifical feeding cannot be distinguished from other forms of medical treatment . . . the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artifical delivery of food and water." *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 288-289 (1990) (O'Connor, J., concurring); "artifical feedings such as nasogastric tubes, gastrostomies, and intravenous infusions are significantly different from bottle-feeding or spoonfeeding — thay are medical porcedures with inherent risks and possible side effects, instituted by skilled health-care providers to compensate for impaired physical functioning," *In re Conroy*, 98 N.J. 321, 373, 486 A.2d 1209, 1236 (1985).

starvation" and not from the vegetative condition that made it impossible for her to eat or drink, one would also have to accept the conclusion that when physicians stop attempted cardiopulmonary resuscitation on a patient in cardiac arrest, what kills the patient is not the cardiac arrest but rather the physician who intentionally stops compressing the heart. Since the failure to perform cardiopulmonary resuscitation always "hastens death," under each court's logic, patients who refuse cardiopulmonary resuscitation would always be committing suicide.

Similarly, the Ninth Circuit Court of Appeals wrongly assumes that physicians who administer drugs for pain relief that could also shorten life *intend* the death of the patients. 79 F.3d at 827. This indicates that the Ninth Circuit Court of Appeals misunderstands the principle of the double effect, in which an action may have two known consequences, only one of which is intended. Thus, the conclusion that pain relief and death are equally intended by a physician who administers a pain-relieving drug that may also shorten life is false. Physicians titrate pain relieving drugs in an attempt to provide maximum effective pain relief without causing death. The principle of the double effect means that treating the patient's pain is acceptable even if the treatment may hasten death. Providing medication to control pain has always been a legitimate and lawful medical act, even if death or suicide is risked. Most invasive medical interventions carry the risk of death or disability. But if a patient dies during surgery, the surgeon is not guilty of homicide. This is because there is a real difference between an intended result and an unintended but accepted consequence of medical care where the goal is to benefit the patient.[8] The difference between

[8] As one of the dissenting judges, Andrew Kleinfeld, in the Ninth Circuit Court of Appeals opinion, properly notes, when General Dwight D. Eisenhower ordered American troops to the beaches in Normandy, he knew he was sending many to certain death, but his purpose was to liberate Europe from the Nazis. Judge Kleinfeld continued, "The majority's theory of ethics would imply that this purpose was legally and ethically indistinguishable from a purpose of killing American soldiers." 79 F.3d at 858 (Kleinfeld, J., dissenting).

intended and unintended but foreseen consequences of medical treatment was also addressed by the first presidential bioethics commission. It concluded that the relevant moral issue:

> . . . is not really that death is forbidden as a means to relieve suffering but is sometimes acceptable if it is merely a foreseeable consequence. Rather, the moral issue is whether or not the decisionmakers have considered the full range of foreseeable effects, have knowingly accepted whatever risk of death is entailed, and have found the risk to be justified in light of the paucity and undesirability of other options.

PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT 82 (1983).

There are other important differences between assisted suicide and refusing treatment. Unlike assisted suicide there are currently no statutes, and there have never been any statutes, that prohibit a person from refusing treatment. Nor have any statutes been necessary to grant individuals the right to refuse treatment.[9] The case law that exists in this area did not come about as a result of individuals attempting to invalidate state law. Rather the case law was developed because individuals were being denied their right to refuse treatment by other individuals, or because someone brought an action in an

[9] All states have adopted "Natural Death Statutes," "living will" laws, health care proxy laws, durable power of attorney laws or similarly entitled statutes. These are all for the purpose of enabling decisionmaking on behalf of *incompetent* persons. They have no relevance to the issue of a competent person's right to make health care decisions for him- or herself except as they extend this right into the state of incompetence.

attempt to force treatment on an unwilling person. Thus, unlike the assisted suicide cases before the Court, the courts have not been asked to invalidate legislative judgments in the refusing treatment cases. Even in *Cruzan*, this Court was not asked to rule on a statute, but on a burden of proof standard that was created by a state supreme court. Moreover, neither the Missouri Supreme Court nor this Court even raised the question of whether withdrawing Nancy Cruzan's feeding tube based on her wishes would violate Missouri's law against physician assisted suicide. The relevance of this to the instant case is to note that legislatures across the county have prohibited assisted suicide but have never prohibited competent persons from refusing treatment. This in and of itself is strong evidence of the difference between treatment refusal and suicide.

The right to refuse treatment is an expression of the patient's autonomy and the right to refuse unwanted bodily invasions. Any competent adult can refuse treatment for any reason. The right of a competent person to refuse treatment has never been conditioned on having a terminal illness or any other medical status. Nor does a patient need the permission or cooperation of a physician to refuse treatment. If a person refuses treatment, the physician may not lawfully treat the person. If the patient withdraws consent to treatment, the physician must cease to treat the person.

In contrast, the purported "right" to physician assisted suicide in the instant cases is defined entirely by a physician's subjective assessment of the patient's circumstances. The person must be found to be "terminally ill" (an undefined and undefinable term), must be in a condition where death will soon occur, and must be suffering in a way a physician finds distressing enough to prescribe the desired drugs. This is unrelated to the right of all individuals to refuse treatment for their own reasons. This Court should affirm the right to refuse treatment and make clear that rejection of the purported right to assisted suicide does not in any way undermine the right to refuse treatment.

II. The Constitutional Right Of Pregnant Women To Terminate A Pregnancy Is Based On Facts And Constitutional Principles That Do Not Encompass Any Asserted Constitutional Right To Physician Assistance In Suicide.

A. *The Constitutional Right of a Pregnant Woman to Terminate her Pregnancy is Based on her Interest in her own Life, Health, and Future.*

The Ninth Circuit Court of Appeals saw no difference between the woman's interest in continuing or terminating a pregnancy, and a terminally ill person's interest in obtaining assistance in committing suicide, finding both "central to personal dignity and autonomy." 79 F.3d at 813-814. But this parallel could be drawn only by misunderstanding the fundamental basis on which the abortion cases have been decided. Constitutional protection of a woman's right does not require also protecting a right to physician assisted suicide.

The Ninth Circuit Court of Appeals reached its conclusion that there is a substantive due process right to determine "the time and manner of death" almost solely on the basis of the following two sentences from the joint opinion in *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992).

> "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."

79 F.3d at 813.

Unlike the Ninth Circuit, however, the joint opinion in *Casey* continued its reasoning after the two sentences quoted above, saying, "These considerations begin our analysis . . . but cannot end it. . . ." 505 U.S. at 852. In *Casey*, as in earlier decisions, this Court recognized a constitutional right related

to "marriage, procreation, contraception, family relationships, child rearing, and education." 505 U.S. at 851. In *Casey*, the Court reaffirmed "the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear or beget a child." 505 U.S. at 851. This choice is so central to a woman's life, health, future, and place in society that only she should be able to make it. This is because, as the joint opinion in *Casey* explained, "abortion is a unique act ... [T]he liberty of a woman is at stake in a sense unique to the human condition and so unique to the law ... The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society." 505 U.S. at 852.

The reasons for protecting a woman's right to choose to continue or terminate a pregnancy simply do not apply beyond pregnant women. A woman's decision whether to have a child determines not only her future relationships with others but her own conception of herself and her role in society. Furthermore, the constitution protects the woman's right in order to ensure that women are treated fairly as free and equal participants in a democracy. ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives." 505 U.S. at 856). The woman's right is thus "implicit in the concept of ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937).

None of these reasons apply to a person who seeks assistance in committing suicide. A decision to commit suicide does not further the goals of reproductive liberty, equality and full participation in the "economic and social life of the nation," values preserved by the Court in *Casey*. Therefore, the Second Circuit Court of Appeals was correct to reject a substantive due process right to assistance in suicide based on the abortion cases. 80 F.3d at 725.

B. *Unlike Other Aspects of Personal Life That Have Been Protected From State Interference by the Constitutional Right of Privacy or Personal Liberty, the Right to Physician Assisted Suicide Is Poorly Defined and Its Exercise Cannot be Limited by Logic or Principle.*

The very core of the constitutional privacy and liberty cases is that individuals have "zones of privacy" into which the government may not enter. These involve decisions that are so personal and important to the individual, and which do not affect the general public, that government simply has no role in limiting the decisions an individual might make in these areas. *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), *Carey* v. *Population Services*, 431 U.S. 678 (1977). *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972). In *Griswold*, by outlawing the use of contraceptives, the state required married people to risk pregnancy or to refrain from marital sexual relations. *Griswold* forbade the state from invading the marital bedroom and controlling the activities that occurred there. In *Eisenstadt* and *Population Services*, the Court extended *Griswold* by properly noting that the decision whether or not to bear or beget a child is a *personal* right that is reserved to every person, and that the state has no role in that highly personal decision. Likewise, in *Roe* v. *Wade*, 410 U.S. 113 (1973), and its progeny, including *Casey*, the Court has continued to recognize this zone of privacy into which the state could not intrude.

What is notable about this line of cases, and the cases which supplied the conceptual foundation for them, *Loving* v. *Virginia*, 388 U.S. 1 (1967), *Stanley* v. *Georgia*, 394 U.S. 567 (1969) and *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925), is that they involved discrete decisions, made by members of a readily identifiable category of individuals, who did not have to justify the reasons for their decisions.

Prior to *Roe*, there were states that permitted a woman to terminate pregnancy if she had a reason the state found

acceptable. Some states permitted a woman to terminate her pregnancy if it endangered her life; others if it endangered her health. Still other states allowed termination of pregnancy if the woman was impregnated as a result of rape or incest, or if the fetus was malformed enough to satisfy the state. The essential underpinning of *Roe* is that it is not for the state to determine whether a woman's reason for terminating her pregnancy is legitimate; rather only the woman herself can make this very private, personal and life changing decision. Because the reasons are so personal, she need not give a reason. This is also true of other decisions that this Court has recognized are protected by the constitutional rights of personal privacy and liberty. Thus, no one needs to justify to the state their reasons for wishing to use contraceptives, or to send their child to a parochial school, or to marry a person of a different race.

In a similar respect, it is clear who comes under the protective umbrella of the right of privacy or personal liberty as applied by this Court. *Every* pregnant woman may choose whether or not to terminate her pregnancy; *every* person who engages in sexual activity may choose whether or not to use contraceptives; *every* parent may choose what type of school their child attends; *every* person may decide whom to marry regardless of race.

In its conclusion, the Ninth Circuit Court of Appeals says, "We hold that a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." 79 F.3d at 838. In stark contrast to contraception, abortion and marriage rights, the scope of the right to assisted suicide as portrayed by the Ninth Circuit Court of Appeals is not ascertainable.

Moreover, unlike the broad classes of people to whom other liberty rights apply, the "right" to suicide assistance described

by Ninth Circuit Court of Appeals only applies to "terminally ill" people. Unlike pregnant women, for example, this is not an objectively definable class. Arguably, anyone who is diagnosed with an incurable, lethal disease is terminally ill. Thus, an AIDS patient with a life expectancy of five years, an 18-year-old with cystic fibrosis and a twelve year life expectancy and a cancer patient who is in the final stages of a disease, are all "terminally ill." In some places the Ninth Circuit Court of Appeals describes a terminally ill patient as one who has an "incurable and painful degenerative disease" that leads to "debilitating pain and humiliating death." 79 F.3d at 821. Elsewhere the court describes patients "wracked by pain and deprived of all pleasure." 79 F.3d at 814. Still elsewhere the court argues that a person who is "reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent," has "a strong liberty interest in choosing a dignified and humane death." 79 F.3d at 814. Obviously these are people who are suffering from different conditions.

The Ninth Circuit Court of Appeals itself acknowledges that the term "terminally ill" does not constitute a "clear line of demarcation." 79 F.3d at 830. But the court draws comfort from the fact that some states in their "natural death laws" have defined terminal illness as meaning death is likely to ensue in six months. It is remarkable that the Ninth Circuit Court of Appeals creates a constitutional right for a class it cannot define in any principled way because some state legislatures have adopted an arbitrary definition (and one that applies to differently-situated people for different reasons). This is a dramatic departure from the thoughtful and precise way this Court has applied the constitutional right of privacy or liberty in other contexts.

The Ninth Circuit Court of Appeals also seems to believe that, unlike the exercise of other rights in this area, it can require people to justify their individual exercise of this right. Thus the court imperiously asserts that a forty-year-old alcoholic has no right to physician assisted suicide but does not explain why his suffering does not entitle him to the rights

the court grants other suffering patients. 79 F.3d at 821. Assume that this person has struggled with his alcoholism for 20 years, has lost his job and family as a result of his drinking, and has repeatedly undergone unsuccessful treatment. Why does the court think that *it* or the *state* can determine that this person's very real, ongoing and life long suffering and humiliation do not meet the constitutional requirements for assisted suicide, but that a cancer patient's suffering at the end of life does? No constitutional principle can distinguish these two cases.

This is not a "slippery slope" argument. The point is that if assisted suicide is a constitutionally protected right to end suffering, then neither the courts nor the states should be able to say how much suffering is enough. That is necessarily a personal judgment to be made by the individual. The very failure of the Ninth Circuit Court of Appeals to recognize this point demonstrates that the "right" to assisted suicide is not like the right to choose to terminate pregnancy or the right to use contraception, and thus is not related to the privacy and liberty rights this Court has previously recognized.

C. *Any Purported Constitutional Right to Physician Assistance in Suicide does not Follow from a Woman's Right to Terminate a Pregnancy because (1) Assistance in Suicide is not a Medical Procedure; and (2) Regulating Physician Assisted Suicide would Require Intrusions into the Physician-Patient Relationship that have been Rejected as Unconstitutional in Implementing a Woman's Decision to Terminate a Pregnancy.*

1. *Assistance in Suicide is not a Medical Proedure.*

Abortion is and has always been a medical procedure, and thus only licensed physicians may lawfully perform abortions. *Roe* described "the abortion decision in all its aspects" as "inherently and primarily a medical decision." 410 U.S. at 165. Unlike abortion, assisting a suicide requires no special

medical skills or knowledge. Assisting patients to commit suicide is not taught in medical schools, tested on any medical board examinations or discussed in the standard medical texts. Self-abortions and abortions done by nonphysicians are dangerous to women's lives and health. The safety of suicide is not an issue. Almost all competent adults are capable of successfully committing suicide, and tens of thousands do so every year in the United States. Assisting suicide is not a medical procedure, and medicalizing an act runs the risk of making an otherwise unacceptable act appear acceptable. The country's most notorious practitioner of assisted suicide, Jack Kevorkian, uses carbon monoxide poisoning, a method that is entirely nonmedical in nature. George J. Annas, *Physician Assisted Suicide — Michigan's Temporary Solution*, 20 Ohio N. U. L. Rev. 561, 568 (1994). Although Kevorkian's medical license has been revoked, no one has ever argued that he should be prosecuted for the unlawful practice of medicine. This is because assisted suicide is not the practice of medicine, and does not require any medical knowledge or access to any medical drugs or devices. The Ninth Circuit Court of Appeals itself recognized that physicians need not be involved in the final act of assisted suicide by extending immunity to cover family members and other nonphysicians. 79 F.3d at 839. This is why, unlike laws against abortion, laws against physician assisted suicide do not have a unique impact on physicians.

The Ninth Circuit Court of Appeals could not explain why the constitutional right to assisted suicide, a right that purportedly belongs to the "terminally ill" person, can or should be limited to assistance by physicians, or to one particular suicide assistance technique, namely prescribing drugs. Unlike abortion, suicide can be accomplished in many nonmedical ways. If there is a right to commit suicide with prescription drugs, then there must also be a right to commit suicide using a gun, if that is what the terminally ill patient so desires. There is no principled way to distinguish between methods of suicide, and it is impossible to create a constitutional right to commit suicide using one means but not another. Indeed,

it is likely, given the lack of training physicians receive in this area, that a person could receive more effective assistance in suicide from an executioner than from a physician.

In 1989, a similar Amicus group of bioethics professors argued to the Court that the constitutional right of privacy protects a woman's right to make the personal medical decision whether to terminate a pregnancy in the privacy of the physician-patient relationship, free from state intrusion. Brief for Bioethicists for Privacy as Amicus Curiae Supporting Appellees in *Webster* v. *Reproductive Health Services*, No. 88-605 (reprinted in the Joint Appendix accompanying *Washington* v. *Glucksberg*, No. 96-110, at 95-127). Amicus believes that the arguments made there remain valid. Nonetheless, accepting them does not require the Court to protect any right to assisted suicide because the decision to commit suicide or to request assistance in suicide is not a personal *medical* decision, and because assisted suicide is not a *medical* procedure.

Assisted suicide is not like abortion. In abortion, the Court protected an activity that necessarily occurred in the confines of the private physician-patient relationship. In assisted suicide, neither physicians nor medical procedures are necessary. Thus, unlike abortion, limiting the right of assisted suicide to aid by physicians is illogical, arbitrary, and not derived from any constitutional principle.

2. *Regulating Physician Assisted Suicide would Require Intrusions into the Physician-Patient Relationship that have been Rejected as Unconstitutional in Implementing a Woman's Decision to Terminate a Pregnancy.*

Abortion is performed in the context of a confidential physician-patient relationship without direct state or third party interference or review. Protection of the right to decide whether to terminate a pregnancy requires keeping the states out of this confidential relationship. In contrast, all proposals to "legalize" physician assisted suicide require or encourage

intrusions into the physician-patient relationship by mandating outside review and approval of the patient's decision. Daniel Callahan & Margot White, *The Legalization of Physician Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Richmond L. Rev. 1, 8-9 (1996). Both Circuit courts called on states to regulate physician assisted suicide to prevent abuses, and the Ninth Circuit Court of Appeals seemed to endorse Oregon's law, the only existing state law on the subject in the U.S. Or. Rev. Stat. §127.800 et seq. (1995).

The Oregon law grants legal immunity for physicians who prescribe lethal medications for their competent terminally ill patients (defined as those with 6 months or less to live) who express a desire to use these drugs to commit suicide. However, prior to writing the prescription, the physician must obtain a request for the prescription, in writing and signed in the presence of at least two witnesses who certify that the patient is competent and acting voluntarily. In addition, at least two physicians must agree that the patient is likely to die from a terminal illness within six months and the patient must be referred for psychiatric or psychological counseling. Finally, waiting periods are built in: two oral requests are required, the second no less than 15 days after the original oral request, and the prescription itself cannot be provided less than 48 hours after the written request. Under *Doe* v. *Bolton*, 410 U.S. 179 (1973), this burdensome and intrusive procedure would not be constitutionally permissible if the right to physician assisted suicide is based on a fundamental liberty interest; in abortion no one gets to second guess the woman's constitutionally-protected decision.

Unlike abortion, physician assisted suicide is recognized, even by the two Circuit Courts of Appeals that have asserted that it is a constitutional right, as far too dangerous a right to be exercised by patients and physicians alone.

The conclusion is inescapable: the woman's right to make decisions regarding abortion is unique, and unlike assisted suicide, protects the life, health, and future well being of women.

CONCLUSION

Amicus therefore respectfully requests this Court to:
1) Reverse the judgment of the Ninth Circuit Court of Appeals,
2) Reverse the judgment of the Second Circuit Court of Appeals,
3) Explicitly recognize that rejection of a constitutional right to physician assistance in committing suicide in no way affects the common law and constitutional right to refuse medical treatment,
4) Explicitly recognize that rejection of a right to physician assistance in committing suicide in no way affects a woman's constitutional right to determine whether or not to terminate her pregnancy.

Respectfully submitted,

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

STATE OF WASHINGTON, ET AL., *Petitioners*,

v.

HAROLD GLUCKSBERG, ET AL., *Respondents*.

&

DENNIS C. VACCO, ET AL., *Petitioners*,

v.

TIMOTHY E. QUILL, ET AL., *Respondents*.

On Writs of Certiorari to the United States Court of Appeals
for the Ninth & Second Circuits

BRIEF AMICI CURIAE OF GARY LEE, M.D., WILLIAM PETTY, M.D., FRITZ BECK, JUNE BECK, WILLOWS RESIDENTIAL CARE FACILITY, SISTER GERALDINE BERNARDS, MARYVILLE NURSING HOME, INC., JANICE ELSNER, CLAUDINE STOTLER, JEFFREY M. WEINKAUF, AND PHYSICIANS FOR COMPASSIONATE CARE IN SUPPORT OF PETITIONERS

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38 pp

QUESTIONS DEALT WITH HEREIN

1. Whether safeguards will protect vulnerable persons from duress, undue influence, and the affects of depression if a constitutional right to assisted suicide is recognized.

2. Whether safeguards will be repeatedly challenged and frequently struck down.

3. Whether the recognition of a constitutional right to assisted suicide will be limited to persons who are competent, terminally ill, and otherwise making a voluntary decision.

TABLE OF CONTENTS

Page

QUESTIONS DEALT WITH HEREIN i

TABLE OF CONTENTS ii

TABLE OF AUTHORITIES iii

INTEREST OF AMICI CURIAE 1

SUMMARY OF THE ARGUMENT 3

ARGUMENT 5

I. SAFEGUARDS WILL NOT PROTECT VULNERABLE PERSONS. 5

II. IF A CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE IS RECOGNIZED, ANY PROPOSED SAFEGUARDS WILL UNDOUBTEDLY BE CHALLENGED AND FREQUENTLY STRUCK DOWN. 19

III. THE RECOGNITION OF A CONSTITUTIONAL RIGHT TO ASSISTED SUICIDE WILL NOT BE LIMITED TO PERSONS WHO ARE TERMINALLY ILL AND MENTALLY COMPETENT. . . 24

CONCLUSION 30

TABLE OF AUTHORITIES

Page(s)

CASES

Akron v. Akron Center for Reproductive Health, 462 U.S. 416 (1983) 20-21

Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) 27

Bellotti v. Baird, 443 U.S. 622 (1979) 21

Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) 25

Brophy v. New England Sinai Hospital, Inc., 398 Mass. 417, 497 N.E.2d 626 (1986) 26

Compassion in Dying v. State of Washington, 49 F.3d 586 (9th Cir. 1995) 10

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) 5, 8, 20, 23

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) 24, 27

Harris v. McRae, 448 U.S. 297 (1980) 22

Hodgson v. Minnesota, 497 U.S. 417 (1990) 22

In re Browning, 568 So.2d 4 (Fla. 1990) 27

In re Conroy, 98 N.J. 321, 486 A.2d 1209 (1985) 27

In re Jobes, 108 N.J. 394, 529 A.2d 434 (1987) 28

In re McAfee, No. D-70960 (Super. Ct. Fulton County, Ga.

Sept, 7, 1989) 26

In re Quinlan 70 N.J. 10, 335 A.2d 647, *cert. denied sub nom.* Garzer v. New Jersey, 429 U.S. 922 (1976) 25

In re Smerdon, slip op. No. A-6031-89T1 (N.J. Super. Ct. App. Div. 1991) 28

In re Sue Ann Lawrance, 579 N.E.2d 32 (Ind. 1991) 28

In re Swan, 569 A.2d 1202 (Me. 1990) 28

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Lee v. State of Oregon, 869 F. Supp. 1491 (D. Or. 1994) 8-9, 11, 13

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Maher v. Roe, 432 U.S. 464 (1977) 22

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Ohio v. Akron Center for Reproductive Health, 497 U.S. 502 (1990) 22

People v. Kevorkian, 447 Mich. 436, 527 N.E.2d 714 (1994) 9

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992) 20, 23, 24

Quill v. Vacco, 80 F.3d 716 (2nd Cir. 1996) 24

Roe v. Wade, 410 U.S. 113 (1973) 20

Schloendorff v. Society of New York Hospital, 211 N.Y.

125, 105 N.E. 92 (1914) 25

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STATUTES

18 Pa. Cons. Stat. § 3205(a)(1)(i) (1983) 21

18 Pa. Cons. Stat. § 3205(a)(1)(ii) (1983) 20

18 Pa. Cons. Stat. § 3205(a)(1)(iv) (1983) 21

18 Pa. Cons. Stat. § 3205(a)(2)(iii) (1983) 20

18 Pa. Cons. Stat. § 3206 (1983) 21

18 Pa. Cons. Stat. § 3215(e) (1983) 22

18 Pa. Cons. Stat. § 3214 (1983) 21

Oregon Ballot Measure 16 . . . . . 7, 19

Oregon Revised Statutes § 161.205 6

Oregon Revised Statutes § 163.117 6

Oregon Revised Statutes § 163.125 6

Oregon Revised Statutes § 426.005 7

Oregon Revised Statutes § 426.070 et seq. 7

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Affidavit of Carol J. Gill, Ph.D. 9, 17

Affidavit of David C. Clark, Ph.D. 13-16

Affidavit of Gary E. Lee, M.D. 17

Affidavit of Jerome A. Motto, M.D. 16, 17

Affidavit of Jerome R. Wernow, Ph.D. 18

Affidavit of Patricia Wesley, M.D. 11, 19

Affidavit of Richard Fenigsen, M.D., Ph.D. 8, 9

Affidavit of Timothy M. Quill, M.D. 8

Affidavit of William Petty, M.D. 18

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INTEREST OF AMICI CURIAE[1]

With one exception, the amici curiae are the plaintiffs who successfully challenged Oregon Ballot Measure 16 which legalized physician-assisted suicide in the state of Oregon. *Lee v. State of Oregon*, 891 F. Supp. 1421 (D.Or. 1995). That case is currently on appeal before the U.S. Court of Appeals for the 9th Circuit. A decision in this case recognizing a constitutional right to physician-assisted suicide would negatively impact their case on appeal. The *Lee* plaintiffs oppose any recognition of a constitutional right to assisted suicide because vulnerable persons cannot be adequately protected from undue influence, duress, and the affects of depression.

Gary Lee, M.D., is a physician licensed in the State of Oregon who is a resident of and practices medicine in Eugene, Oregon. All of his patients are cancer patients, many of whom will die with advanced cancer. Many of these patients suffer from depression; however, physicians are not well-trained in diagnosing depression so this problem is generally undertreated. Depression makes patients who have the disability of a terminal disease highly susceptible to undue influence in the form of suggestions that their lives are not worth living. He asserts the interests of his patients who have the disability of a terminal disease who do not wish to engage in assisted suicide but may be subject to internal and external pressures toward assisted suicide which they may be unable to resist given the lack of appropriate safeguards.

William Petty, M.D., is a physician licensed in the State of Oregon who is a resident of and practices medicine in Portland, Oregon. Eighty percent of his patients are cancer patients, and many will die as a result of their disease. He observes that these patients are especially susceptible to undue influence because they become vulnerable and compliant. He asserts the interests of his patients who have the disability of a terminal disease.

Janet Elsner is a person with progressive muscular dystrophy who uses a wheelchair. She is 46 years old and is a resident of Portland, Oregon. Ms. Elsner has had periods where she is so weak that she is limited to a liquid diet because she is too tired to

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[1]Consents from the parties to filing this brief have been filed with the Clerk.

eat. At such times, she cannot even turn over in bed. She does not know how long she has to live and has already lived longer than expected. She has problems with depression as a result of her illness and understands that depression may go undiagnosed and cause persons to consider suicide. She joins this brief on her own behalf and as a representative of those persons who have the disability of a terminal disease even with medical treatment.

Claudine Stotler is a resident of Washington County, Oregon, who has been diagnosed by her physician with cancer from which she will die. Ms. Stotler would never want to consider assisted suicide but understands that persons who have the disability of a terminal disease are sometimes subject to undiagnosed depression or undue influence while in a debilitated state and become persuaded to act contrary to their true intent, which she would never want to happen to her. She has been subject to depression at times since being diagnosed with cancer. She joins this brief on her own behalf and as a representative of those persons who have the disability of a terminal disease even with medical treatment.

Jeffrey M. Weinkauf is an insulin-dependent individual with diabetes, who is a resident of Eugene, Oregon. Oregon Ballot Measure 16 defines "terminal disease" as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six (6) months." Under this definition, Mr. Weinkauf's diabetes might constitute a terminal disease because it is an incurable and irreversible disease and, without insulin treatment, he will die within six months. The statute thus does not differentiate between diseases which are controllable with regular medication and those which are not. He joins this brief in his own behalf and as a representative of those persons who have a possibly terminal disease absent medical treatment.

Fritz and June Beck are residents of Bandon, Oregon, and are owners of The Willows Residential Care Facility, located in Bandon. Sister Geraldine Bernards is an Oregon resident and the Administrator of the Maryville Nursing Home, Inc., located in Beaverton, Oregon. These nursing homes house persons who have the disability of a terminal disease. If assisted suicide is legalized,

they would be required to permit the assisted suicide of a patient who has the disability of a terminal illness in their facility under Oregon Ballot Measure 16. Furthermore, they would be required to appoint a witness to witness any written consents to assisted suicide and would be prohibited from excluding physicians who wish to commit assisted suicide on their premises from prescribing lethal drugs to qualified residents of their facility. Because of their strong religious opposition to such practice, they believe they would have their free exercise of religion violated, contrary to the guarantees of the First Amendment and the Religious Freedom Restoration Act. In addition, they believe their First Amendment right to freedom of association would be violated if they were forced to allow assisted suicide to occur in their facility.

Physicians for Compassionate Care (PCC) is an Oregon nonprofit corporation with membership open to physicians, nurses, and other health care professionals. Its membership consists of over 500 health care professionals. Its purpose is to promote compassionate care for severely ill patients without sanctioning or assisting their suicide. Members affirm an ethic based on the principle that all human life is inherently valuable and that the physician's roles are to heal illness, alleviate suffering, and prolong life. Most of the organization's members treat patients who are terminally ill. It was not a plaintiff in the *Lee v. Oregon* case.

SUMMARY OF THE ARGUMENT

What this Court is being asked to do is to recognize a right to assisted suicide (by lethal dose of drugs) for competent people which will invalidate all state laws prohibiting assisted suicide. This brief will present three public policy reasons why such a constitutional right should not be recognized.

First, the decision of the 9th Circuit assumes that "sufficient safeguards can and will be developed by the state and medical profession." However, there are no safeguards that will be sufficient to protect vulnerable persons from duress, undue influence, and the affects of depression if a constitutional right to assisted suicide is recognized. This can be seen by an analysis of the safeguards in Oregon Ballot Measure 16, which became law in

November 1994, but was enjoined prior to its effective date by the U.S. District Court. At first blush, these safeguards seem reasonable enough and they are probably typical of the type of safeguards that will be proposed whenever assisted suicide is legalized. However, these safeguards are inadequate because they clearly fail to protect vulnerable persons. The record of the Oregon case, upon which the preliminary and final injunctions were issued, establishes certain key facts, which are summarized as follows: (1) physicians are unable to accurately diagnose a person as having a "terminal disease"; (2) people with terminal illness commonly suffer from the psychiatric illness of depression or other form of impaired judgment; (3) primary care physicians have difficulty in diagnosing depression; (4) depression is a major factor leading to suicide; (5) depression is treatable; (6) major life decisions should not be made while one is depressed; (7) recovery from depression takes more than 15 days; (8) patients with terminal illness are vulnerable to external pressures and abuse; and (9) drug overdoses are notoriously unreliable in actually causing death. For these reasons, the typical safeguards being proposed today are inadequate to protect the lives of vulnerable persons from undue influence, duress, and clinical depression.

Second, any proposed safeguards will undoubtedly be challenged and frequently struck down. This can be seen from the abortion litigation of the past twenty-five years. The 9th Circuit recognized this fact when it stated: "In deciding 'right-to-die' cases, we are guided by th[is] Court's approach to the abortion cases." Because abortion safeguards have been repeatedly challenged and frequently struck down in the past, we can expect the same result regarding any proposed assisted suicide safeguards. Therefore, if this court recognizes a new constitutional right to assisted suicide, the abortion precedents will control and will result in the striking down of many if not most safeguards. Physician-assisted suicide will be uncontrollable.

Third, the recognition of a constitutional right to assisted suicide will not be limited to persons who are terminally ill and mentally competent. The case law establishing a right to refuse life-sustaining medical treatment is binding precedent which will

permit assisted suicide for persons who are not terminally ill, and surrogate decisionmaking for persons who are incompetent, comatose, or in a persistent vegetative state. The 9th Circuit recognized this when it specifically included "the act of refusing or terminating unwanted medical treatment" within the liberty interest it was examining. Similarly, if a right to assisted suicide is recognized, equal protection clause jurisprudence will require the recognition of a right to euthanasia (by lethal injection) for those who cannot take a lethal dose by mouth, and a right to mercy killing for those who are incompetent, comatose, or in a persistent vegetative state or otherwise unable to exercise their constitutional rights without assistance. Physician-assisted suicide will necessarily result in the legalization of euthanasia and mercy killing.

For these public policy reasons this Court should hold that there is no right to assisted suicide in the Constitution of the United States, and should find that the decisions of the Second and Ninth Circuits should be reversed and/or vacated.

ARGUMENT

I. Safeguards Will Not Protect Vulnerable Persons.

In *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996), the 9th Circuit held that "a liberty interest exists in the choice of how and when one dies, and that the provision of the Washington statute banning assisted suicide, as applied to competent terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors, violates the Due Process Clause." *Id.* at 838. It also stated that "we believe that sufficient safeguards can and will be developed by the state and medical profession to ensure that the possibility of error will ordinarily be remote." *Id.* at 824. When the medical facts are analyzed, it is clear that the safeguards envisioned by the court will not be sufficient to protect vulnerable persons. The 9th Circuit cites the procedural safeguards in Oregon's Ballot Measure 16 as "a good example of how these legitimate and important concerns [i.e., errors, abuses, and legitimate state interests] can be addressed effectively." *Id.* at 833 & n.122.

The State of Oregon is the first state to legalize physician-

assisted suicide. However, before the law went into effect, it was successfully challenged by the *amici* herein, who are the plaintiffs in the case of *Lee v. Oregon*, 891 F. Supp. 1421 (D. Or. 1995). The U.S. District Court issued preliminary and permanent injunctions. *Id.* at 1439 (permanent injunction); 869 F. Supp. 1491 (D. Or. 1994) (preliminary injunction). It is now on appeal before the U.S. Court of Appeals for the 9th Circuit. A right to assisted suicide, whether created by referendum, by statute, or by recognition of a new constitutional right, constitutes an exception to the plethora of state laws protecting vulnerable persons. For example, the following Oregon statutes protect its vulnerable citizens.

Oregon Revised Statutes § 163.117 provides that:

> It is a defense to a charge of murder that the defendant's conduct consisted of causing or aiding, without the use of duress or deception, another person to commit suicide. Nothing contained in this section shall constitute a defense to a prosecution for, or preclude a conviction of, manslaughter or any other crime.

Oregon Revised Statutes § 163.125 provides that:

> (1) Criminal homicide constitutes manslaughter in the second degree when:
>
> (a) It is committed recklessly; or
>
> (b) A person intentionally causes or aids another person to commit suicide.
>
> (2) Manslaughter in the second degree is a Class B felony.

Oregon Revised Statutes § 161.205 provides that:

> The use of physical force upon another person that would otherwise constitute an offense is justifiable and not criminal under any of the following circumstances: . . . . (4) A person acting under a reasonable belief that another person is about to commit suicide or to inflict serious physical self-injury may use physical force upon that person to the extent that the person reasonably believes it necessary to thwart the result.

Oregon Revised Statutes § 426.005 defines a "mentally ill person" as, inter alia, "a person who, because of a mental disorder is . . . [d]angerous to self . . . ." Oregon Revised Statutes

§ 426.070 et seq. provide commitment proceedings for one who is a "mentally ill person," including emergency commitment proceedings.

While the foregoing statutes protect most Oregon residents from self-harm and assisted suicide, Oregon has by Ballot Measure 16 determined that the lives of persons who have the disability of a terminal disease, who are suffering from depression or undue influence, are not entitled to the same protections from self-harm and assisted suicide as those not deemed terminally ill.

The following are the relevant provisions of Ballot Measure 16: (1) a written request by an adult who has been determined by two physicians to be suffering from a terminal disease; (2) two witnesses who attest that the patient is capable, acting voluntarily, and not under coercion; (3) the attending physician shall inform the patient of his diagnosis, prognosis, potential risks in taking a lethal medication, the probable result, and the feasible alternatives; (4) the consulting physician shall examine the patient and his records, confirm in writing the diagnosis, verify that the patient is capable and acting voluntarily; (5) if either physician thinks the patient may be suffering from a psychiatric or psychological disorder, or depression, he will refer the patient for counseling; (6) the attending physician shall ask the patient to notify the next of kin of his request for medication; (7) a fifteen day waiting period; (8) civil and criminal immunities for the physicians and health care providers. At first blush, these safeguards seem reasonable enough and they are probably typical of the type of safeguards that will be proposed whenever assisted suicide is legalized.[2]

However, these safeguards are inadequate because they clearly fail to protect vulnerable persons. The record of the Oregon case, upon which the preliminary and final injunctions were issued, establishes certain key facts, which are summarized as follows: (1) physicians are unable to accurately diagnose a person as having a "terminal disease"; (2) people with terminal illness commonly

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[2]These are the type of "appropriate, reasonable, and properly drawn safeguards" suggested by the 9th Circuit. Compassion in Dying v. State of Washington, 79 F.3d 790, 833 (listing example safeguards that could be adopted).

suffer from the psychiatric illness of depression or other form of impaired judgment; (3) primary care physicians have difficulty in diagnosing depression; (4) depression is a major factor leading to suicide; (5) depression is treatable; (6) major life decisions should not be made while one is depressed; (7) recovery from depression takes more than 15 days; (8) patients with terminal illness are vulnerable to external pressures and abuse; and (9) drug overdoses are notoriously unreliable in actually causing death.

First, physicians are unable to accurately diagnose a person as having a "terminal disease." The U.S. District Court in Oregon found that "physicians often misdiagnose terminal illness" and that "a physician's prognosis of six months to live is often fallible." *Lee v. State of Oregon*, 869 F. Supp. 1491, 1497. The *Affidavit of Richard Fenigsen, M.D., Ph.D.*[3] gives evidence of a 20-40% error rate even in the clinical diagnosis of a particular disease. *Fenigsen Affidavit* at ¶ 6. The Oregon defendants did not contest this fact. In one study, lung cancer was misdiagnosed in over 49% of the cases. *Id.* A report in the *British Medical Journal* of four patients referred to a hospice for terminal care with "untreatable cancer" revealed that they had neither terminal illness nor cancer. *Id.* at ¶ 7. "One of these patients had the [erroneous] diagnosis of cancer established (from pleural biopsy) by two pathologists and confirmed by a third." *Id.* Defendants did not contest these facts. As to the ability of a physician to predict that a patient will die of a disease within a certain amount of time, even if correctly diagnosed, that ability is "notoriously fallible." *Id.* at ¶ 17. Oregon defendants' *Affidavit of Timothy M. Quill, M.D.* (C.R. 84) appends an article by Dr. Quill in which he writes, "we acknowledge the inexactness of such prognostications [about whether a patient is

[3]Appellees' Supplemental Excerpts of Record 111 (hereinafter Supp. E.R.), Clerk's Record 33 (hereinafter C.R.), Lee v. Harcleroad, Nos. 95-35804, 95-35805, 95-35854, 95-35948, 95-35949 (9th Cir. Jan. 24, 1996). Richard Fenigsen, M.D., Ph.D., has forty years of experience with severely ill and dying patients in the Netherlands. He has twenty years experience with euthanasia and physician-assisted suicide as practiced in hospitals and by family physicians in the Netherlands. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1497.

'near death']." *Id.* at Appendix D-2. According to the Michigan Supreme Court, "[n]o clear definition of 'terminal illness' is medically or legally possible, since only in hindsight is it known with certainty when someone is going to die." *People v. Kevorkian*, 447 Mich. 436, 467 n.34, 527 N.E.2d 714, 726 n. 33 (1994). Thus, the purported safeguard of a "medically confirmed diagnosis carries a risk of error ranging from 20 to 40 percent." *Fenigsen Affidavit* at ¶ 8. Clearly, many "qualified patients" under Measure 16 will not actually be within six months of dying as Measure 16 envisions.

Second, people with terminal illness commonly suffer from the psychiatric illness of depression or another form of impaired judgment. The *Affidavit of Carol J. Gill, Ph.D.*[4] establishes that

> [m]ost crisis intervention models allow a *minimum* of five weeks for resolution of the acute emotional disorder attending major personal loss. Crisis counselors recognize that the judgment of a person who is *legally* competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Receiving a diagnosis of a terminal disease is clearly a major life stress and personal loss. A pamphlet entitled *Depression: What You Need to Know*, published by the National Institute of Mental Health (no date), at 4, and placed in the *Lee v. Oregon* record as an attachment to the affidavit of Intervenor Levin (Exhibit 28 to Exhibits to Intervenor Levin's "Motions Against Plaintiffs' Claims"; C.R. 149), confirms Dr.

[4]Supp. E.R. 21, C.R. 29. Carol J. Gill, Ph.D., is a clinical psychologist specializing in issues affecting persons with disabilities, pain, and/or chronic illnesses. She has worked clinically with this population in both hospital settings and private practice. Her former positions include: Director of Rehabilitation Psychology at Glendale Adventist Medical Center, Commissioner in Psychology on the Los Angeles County Commission on Disability; and Acting Director of the Program in Disability and Society at the University of Southern California. For the past five years, she has devoted her professional life to research and education projects concerning persons with disabilities and chronic illness. She is currently the President of the Chicago Institute of Disability Research. Her affidavit was cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

Gill's assertion, stating that: "A serious loss, chronic illness, difficult relationship, financial problem, or any unwelcome change in life patterns can also trigger a depressive episode." Thus, many people with the major life stress of a diagnosis of terminal illness will suffer from depression, whether or not it rises to the level of clinical or major depression, and will have impaired judgment for making life and death decisions, even though legally competent. The New York State Task Force on Life and Law, in an exhaustive study entitled *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994),[5] noted that "[i]ndividuals with serious chronic and terminal illness face an increased risk of suicide—some studies suggest that the risk for cancer patients is about twice that of the general population." New York Task Force at 13. The New York Task Force summed up the link between terminal illness and depression as follows:

> Depression may coincide with other medical conditions for several reasons. First, the medical condition may biologically cause depression. Second, the condition may trigger depression in patients who are genetically predisposed to depression. Third, the presence of illness of disease can psychologically cause depression, as is often observed in patients with cancer. Finally, especially for cancer patients, some treatments or medications have side effects that cause depressive moods or symptoms.

New York Task Force at 15. However, the task force found that

> [i]t is a myth . . . that severe clinical depression is a normal and expected component of terminal illness. Healthy individuals, including health care professionals, often believe that it is normal for terminally ill patients to experience major depression. They understand feelings of hopelessness as expected and

[5]The task force was convened in 1985 by Governor Mario Cuomo, who charged the twenty-five-member body with developing recommendations for state public policy on a variety of issues. The report, hereinafter referred to as "New York Task Force," has been recognized as authoritative and relied upon by the Ninth Circuit Court of Appeals in the case of *Compassion in Dying v. State of Washington*, 49 F.3d 586 (9th Cir. 1995).

> rational given the patient's condition and prognosis.

New York Task Force at 16. Further, some will clearly be at risk for depression at the time when they take the lethal overdose, when Measure 16 provides no safeguards to screen out those who are acting incompetently.

Third, primary care physicians have difficulty in diagnosing depression. In the *Affidavit of Patricia Wesley, M.D.*,[6] Dr. Wesley, a psychiatrist and neurologist teaching in the Department of Psychiatry at Yale, cites a study by "David Clark, a major researcher in suicides, and others," of men 65 years and older who committed suicide. *Id.* at ¶ 26 (*citing* David C. Clark, *"Rational" Suicide and People with Terminal Conditions or Disabilities*, 8 Issues in Law & Med. 147, 152 (1992)). The study showed that

> 25% had been to a physician within 24 hours of death, 41% within one week of death, and 70% within one month of death. These contacts were for vague physical complaints. The general physician did not, and probably could not have, picked up either the psychiatric condition or the suicidal intention, at least as they were diagnosed retrospectively, by the psychological autopsy technique used in this study.

Id. Dr. Wesley concluded:

> The above data indicate that it is not an easy task to diagnose either psychiatric illness or suicidality, and that such tasks are probably beyond the expertise of most non-psychiatric physicians. Nonetheless, [Measure 16] asks just such busy, front-

[6]Supp. E.R. 11, C.R. 28. Patricia Wesley, M.D., is an assistant clinical professor of psychiatry in the Department of Psychiatry, School of Medicine, Yale University, New Haven, CT, where she supervises psychiatric residents in their outpatient psychotherapy work. Her other professional responsibilities include the evaluation and treatment of seriously and persistently mentally ill individuals in two outpatient facilities in New York City. One of these facilities exclusively serves individuals 55 and over, many of whom have significant medical problems. While she does not personally manage their medical conditions, she has gained considerable exposure to the impact of significant medical illness on psychological functioning. Her affidavit was quoted and cited by the Oregon District Court at 869 F. Supp. at 1498 n.2.

line, untrained physicians to perform this vital screening function. It will inevitably be done poorly, and many whose wish to die is based on psychiatric disturbance will be aided in killing themselves.

Id. at ¶ 27. Dr. David C. Clark concurs that psychiatric evaluation and treatment is necessary for terminally ill persons seeking suicide:

> The definitions of "attending physician" and "consulting physician" in the Act permit any licensed physician, regardless of experience or specialty training, to function in these roles. There is no requirement that either party have any knowledge or expertise in evaluating mental status, cognitive state and functioning, or psychiatric disorder beyond the fundamentals most physicians are exposed to in medical school. The medical/surgical literature is very clear and consistent in showing that medical/surgical general practitioners and specialists (other than psychiatrists) fail to recognize at least half of all cases of clear-cut major depressive illness in their own practices—i.e., among their own patients—and then they are not successful at recognizing the more severe half of cases. It is my professional opinion that the Act should include a requirement that trained and experienced mental health professionals examine each patient who makes a request for assisted suicide. This would protect people who, in the state of clinical depression, request assisted suicide without the opportunity for treatment.

Affidavit of David C. Clark, Ph.D.[7] at ¶ 27. The latest literature on suicidology confirms the above facts. In the September-October 1995 issue of *Psychomatics*, Harvard Medical School psychiatrists Block and Billings confirm that:

> [d]epression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. Because of the irrevocability of hastening death, decisions about competency must be especially rigorous. Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices. Very rarely are nonpsychiatric clinicians adequately prepared to address this broad concept of competence, so psychiatric input is essential.

Susan M. Block, M.D. & J. Andrew Billings, M.D., *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 5 Psychosomatics 445, 452 (1995). In the August 1995 issue of the *American Journal of Psychiatry*, a team of seven psychiatrists and other researchers reported the results of a Canadian study on the desire for death in the terminally ill—that terminally ill persons who desire death do so because of depression—and urged psychiatric involvement in such cases. Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995).

The Oregon record clearly shows on empirical evidence that there *is* "reason to believe" that primary care physicians, who are concededly not specially trained to diagnose and treat depression, are not capable at discovering, diagnosing, and treating depression. Finally, this fact is confirmed by the New York Task Force:[8]

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[7]Supp. E.R. 89, C.R. 32. David C. Clark, Ph.D., is Professor of Psychiatry, Psychology, and Preventive Medicine, and Director of the Center for Suicide Research and Prevention, at the Rush-Presbyterian-St. Luke's Medical Center, Chicago, Illinois. His supplemental affidavit was cited by the Oregon District Court at 869 F. Supp. at 1501 n.4.

[8]The New York Task Force may be viewed as an impartial voice because it included both persons who favored and opposed assisted suicide personally, but all agreed that, even with attempted safeguards, there is too great a "risk of harm" in implementing a regime of state-endorsed assisted suicide, a risk which "is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized group." New York Task Force at 119.

> Even psychologists and psychiatrist who routinely treat and diagnose depression may have limited experience doing so for patients who are terminally or chronically ill. For those patients, clinicians must be able to distinguish realistic sadness and sense of loss that accompanies such illness from severe clinical depression or the psychiatric disorders that impair decision-making capacity. These disorders are prevalent in those patients who ultimately choose to commit or attempt suicide.

New York Task Force at 127-28.[9]

Fourth, depression[10] is a major factor leading to suicide. "Suicide is the eighth leading cause of death in the United States" and "is a major health problem." *Affidavit of David C. Clark, M.D. (Supp. E.R. 89; C.R. 32; at ¶ 3).* "Those aged sixty-five and over make up 12% of the population but account for 21% of all suicides." *Id.* Major suicide researcher Dr. David Clark reports:

> There is considerable agreement among the findings from the large community-based psychological autopsy studies on the relationship between major mental disorder and death by suicide. Never less than 88% of the subjects qualified for a psychiatric diagnosis at the time of the suicide (never less than 94% in all but one study). . . . Thus suicides rarely occur in

[9]Even where depression is diagnosed, it is often undertreated, New York Task Force at 127, leaving terminally ill persons at risk for suicide both because depression is undiagnosed and because it is undertreated.

[10]The term "depression" is used here and elsewhere herein as a shorthand expression for a range of judgment impairing psychopathologies. Because space and readability do not permit continued reference to a string of psychiatric diagnoses that may lead to suicide, necessity dictates that a shorthand substitute be used. The *Affidavit of David C. Clark, Ph.D.* (Supp. E.R. 89; C.R. 32) sets forth the wide range of psychopathologies which lead to suicide, including depression. Other treatable causes of suicidal ideation and attempt include unrelieved pain and suffering, substance abuse, organic problems, and side effects of certain treatments. While these latter are not psychiatric problems, they represent treatable conditions which can lead to suicidal impulses and should be recalled when the shorthand term "depression" is used herein.

> the absence of major psycho-pathology.

Id. at ¶ 4. Further, "15% of persons with major depression die by suicide." *Id.* at ¶ 6. A Canadian study on the desire for death in the terminally ill, reported in the August 1985 issue of the *American Journal of Psychiatry*, confirms the connection: "in the logistic regression analysis, depression emerged as the only predictor for the desire for death." Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995). The authors of the article cautioned that: "our findings indicate that a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." *Id.* A 1986 study, reported in the *American Journal of Psychiatry* questioned, on the basis of empirical evidence, "[t]he role of terminal illness, physical decline, or chronic pain as a reason for suicide." *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶ 19. Dr. Clark reports of the study that

> Brown and colleagues, in a study of hospice patients diagnosed with terminal illness, severe pain, disfigurement, or disability, found that the great majority of these patients did not desire to die by suicide. Of the small percentage who expressed any wish to die, all met diagnostic criteria for major depressive illness.

Id. at ¶ 20.[11] From this and other evidence, Dr. Clark concluded:

> While it is compelling to assume that many persons with chronic, painful, or terminal illnesses will choose to end their suffering prematurely by opting for suicide, in fact this type of choice, usually referred to as "rational" suicide, is rarely seen in hospital and hospice work. Except in those cases where physical illness is accompanied by a major depressive illness,

[11]Such empirical evidence belies the notion that it is normal and rational for persons with a terminal illness to be depressed and want to kill themselves. *See also Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶¶ 9-12, 19-21, 23-25.

> the great majority of patients spontaneously reject the suicide option and choose to die naturally. The majority of terminally ill patients cling to life throughout their illnesses. Among older person, for whom chronic painful illnesses are not uncommon, only 0.5% of male deaths and 0.2% of female deaths are attributable to suicide.

Id. at ¶ 19. Clark concludes that

> [t]o wish to end life by killing oneself is almost always a serious symptom arising from a temporary psychiatric illness, even when the person is terminally ill. While the subtlety and complexity of depressive illnesses often make it difficult for loved ones to recognize the gravity of the problem, it is generally a mistake to assume that a wish to die or end one's own life is a rational, carefully thought-through decision justified by a person's life situation or health status. One should always suspect that an unrecognized psychiatric illness has silently, invisibly influenced the judgment of a patient opting for suicide. When a patient asks to die, the burden of proof should lie with those who wish to defend as "rational" a decision to die by suicide.

Id. at ¶ 31. The Oregon defendants' *Affidavit of Jerome A. Motto, M.D.* (C.R. 87) provides corroborating evidence of the link between depression and suicide, conceding that, by this criteria, half of all persons committing suicide "suffer from a psychiatric disorder" and that "one-third of all suicides suffer from clinical depression." *Id.* at ¶ 5.[12] Finally, the New York Task Force documented that "As explained by one sociologist who studied suicide: 'It is undeniable that all persons—100 percent—who commit suicide are perturbed and experiencing unbearable psychological pain.'" New York Task Force at 95 n.65 (quoting Edwin S. Schneidman, *Rational Suicide and Psychiatric Disorders*,

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[12]Other treatable reasons people seek suicide include unrelieved pain and suffering, New York Task Force at 128; substance abuse, *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89, 91 ¶ 4; C.R. 32); psychological suffering, New Task Force at 94-95; and psychological pressure, *Affidavit of Gary E. Lee, M.D.* (Supp. E.R. 159, 162 ¶ 9; C.R. 36).

326 New Eng. J. Med. 889 (1992)).

Fifth, depression is treatable. "[D]epressed patients generally respond well to standard treatments for depressive illness—psychotherapy and some antidepressant medication." *Affidavit of David C. Clark, M.D.* (Supp. E.R. 89; C.R. 32) at ¶ 21. "In response to treatment, patients with terminal illnesses and intractable pain are usually grateful that no one facilitated their suicide while they were temporarily depressed or having acute difficulties with pain." *Id.* Oregon defendants' *Affidavit of Jerome A. Motto, M.D.* (C.R. 87) declares that Major Depressive Disorder, the "type of mood disorder that is often associated with suicidal states," "can usually be treated effectively with antidepressant medication." *Id.* at ¶ 4.

Sixth, major life decisions should not be made while one is depressed. As already noted, the *Affidavit of Carol J. Gill, Ph. D.* (Supp. E.R. 21; C.R. 29) establishes that

> [m]ost crisis intervention models allow a *minimum* of five weeks for resolution of the acute emotional disorder attending major personal loss. Crisis counselors recognize that the judgment of a person who is *legally* competent and grossly oriented to reality and logic may nonetheless be emotionally distorted when reacting to overwhelming loss.

Id. at ¶ 18 (emphasis in original). Dr. Gill continues: "[c]lients in crisis therapy are, therefore, cautioned not to make any major life decisions within five weeks of a critical life stress. The Act needlessly narrows this window to fifteen days." *Id.* The assertion that important decisions should not be made while one is depressed is uncontested.

Seventh, treatment for depression takes more than 15 days. As noted in the material quoted in the previous paragraph, resolution of acute emotional disorders takes a minimum of five weeks for resolution. This is uncontested. If treated depression will not resolve itself in less than five weeks, then 15 days is clearly too short a time for depression to resolve itself if undetected and untreated.

Eighth, patients with terminal illness are vulnerable to external

pressures and abuse. "[D]emoralizations and a lack of assertiveness may render the depressed terminally ill patient more vulnerable to the suggestions of others, thereby increasing the potential for abuse." Harvey M. Chochinov, M.D., Keith G. Wilson, Ph.D., Murray Enns, M.D., Neil Mowchun, M.D., Sheila Lander, R.N., Martin Levitt, M.D. & Jennifer J. Clinch, M.A., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1190 (1995). *See also Affidavit of William Petty, M.D.*[13]

Ninth, drug overdoses are notoriously unreliable in actually causing death. Dr. Jerome R. Wernow, a pharmacist, has submitted evidence that 25% of assisted suicides will fail, based on the writings of Derek Humphrey, a Measure 16 proponent and a co-founder of the Hemlock Society (which advocates legalization of physician-assisted suicide and euthanasia). *Affidavit of Jerome R. Wernow, Ph.D.*[14] Dr. Wernow also cites evidence that barbiturate poisoning is the "most uncertain way of taking one's life," *id.* at ¶ 8, raising the specter of patient coma, renal damage, toxic psychosis, serious central nervous system damage, and protracted suffering for the patient and her family. *Id.* at ¶¶ 9-10.

From all these medical facts, Dr. Patricia Wesley, a psychiatrist teaching at the Department of Psychiatry at Yale, has concluded that

> [a]s David Clark puts it, "when a patient asks to die, the burden of proof should be with those who wish to defend a wish to die by suicide as a rational decision." Oregon's Death with Dignity Act has it precisely the other way round, and regards a terminally ill person's suicidal wishes as deserving of speedy implementation, unless proven otherwise. This law flies in the face of what we know about suicide and the

[13]Supp. E.R. 1, C.R. 23, at ¶ 10. William Petty, M.D., is one of the Plaintiffs in Lee v. Harcleroad (Oregon), and is a physician with offices in Portland, Oregon. Eighty percent of his patients are cancer patients.

[14]Supp. E.R. 169, C.R. 169, at ¶ 7. Jerome R. Wernow, Ph.D., is a pharmacist and biomedical ethicist in Oregon. His affidavit was cited by the Oregon District Court at 869 F. Supp. at 1502 n.5.

terminally ill.

Affidavit of Patricia Wesley, M.D. (Supp. E.R. 11; C.R. 28) at ¶ 30. As discussed *infra* this reversal of presumptions from those established by the facts of modern suicidology is irrational and based on erroneous, unscientific stereotypes about why people commit suicide.

The safeguards in Oregon Measure 16 are typical of the type of safeguards being proposed to protect against abuse. However, as can be seen from the above evidence and argument, those safeguards will be inadequate to protect the lives of vulnerable persons from undue influence, duress, and clinical depression.

II. If a Constitutional Right to Assisted Suicide is Recognized, Any Proposed Safeguards Will Undoubtedly Be Challenged and Frequently Struck Down.

The abortion litigation precedents of the past twenty-five years will control any new constitutional right to assisted suicide. The 9th Circuit declared:

> In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. Casey in particular provides a powerful precedent, for in that case the Court had the opportunity to evaluate its past decisions and to determine whether to adhere to its original judgment. Although Casey was influenced by the doctrine of stare decisis, the fundamental message of that case lies in its statements regarding the type of issue that confronts us here: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment."

79 F.3d 801, 813-14 (citing *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833, 851). Thus, the right to die is founded upon and defined by abortion jurisprudence and precedents. If assisted suicide receives constitutional recognition, it is destined to become a super protected right like abortion.

The super protected right of abortion is illustrated by the fact that abortion safeguards have been repeatedly challenged and

frequently struck down. The following are a few examples of the abortion safeguards which have been challenged and defeated. It is clearly foreseeable that assisted suicide safeguards will also be challenged and defeated.

First, the 1986 case of *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747 (1986), demonstrates the problem states have in predicting and conforming to this Court's constitutional boundaries in forth in *Roe*.[15] As Justice O'Connor wrote in her dissent to *Akron*, the "bright lines" have become "blurred."[16] The challenged provisions of the Pennsylvania law in *Thornburgh* included an informed consent provision. It required physicians to make available state-prepared information concerning alternatives to abortion, available assistance for alternatives, and objective information regarding fetal characteristics and the possibility of fetal survival.[17] The physician was required to disclose (1) the possibility of unforeseeable psychological and physical risks of abortion,[18] (2) the availability of medical assistance benefits for prenatal care, childbirth, and neonatal care,[19] (3) the liability of the father for child support,[20] and (4) the probable gestational age of the fetus.[21] The court of appeals invalidated all of these provisions on the basis of this Court's decision in *Akron*.[22] We may expect that similarly detailed

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[15]Roe v. Wade, 410 U.S. 113 (1973).

[16]Akron v. Akron Center for Reproductive Health, 462 U.S. 416, 455 (1983) (O'Connor, J., dissenting).

[17]18 Pa. Cons. Stat. § 3205(a)(2)(iii) (1983).

[18]*Id.* § 3205(a)(1)(ii).

[19]*Id.* § 3205(a)(2)(i).

[20]*Id.* § 3205(a)(2)(ii).

[21]*Id.* § 3205(a)(1)(iv).

[22]*Thornburgh*, 737 F.2d at 295-96. *See Akron*, 462 U.S. at 444-45. *But see*

informed consent requirements for assisted suicide will also be struck down.

Pennsylvania also included a parental consent provision which essentially codified the Supreme Court's holding in *Bellotti v. Baird*.[23] The appeals court enjoined enforcement of this until the Pennsylvania Supreme Court promulgated implementing regulations.[24] We expect that minors will also be recognized to have a right to assisted suicide and that parental consent requirements will be closely scrutinized so as to prevent any unconstitutional burden on the minor's exercise of his or her constitutional right to assisted suicide.

The Pennsylvania Act also required physicians to provide reports with a variety of data for statistical purposes.[25] Included was a report of the basis for the physician's determination that the fetus was not viable or "that the abortion [was] necessary to preserve maternal life or health."[26] The court of appeals invalidated these requirements because they were too extensive and complicated and, hence, were likely to increase the cost of an abortion and possibly have a chilling effect on physicians' willingness to perform abortions.[27] Reporting requirements for assisted suicide will likewise be considered unnecessary and burdensome.

Another Pennsylvania provision required health insurers to

Brief for the United States, *supra* note 17, at 7-8.

[23]18 Pa. Cons. Stat. § 3206 (1983). *See* Bellotti v. Baird, 443 U.S. 622, 648-51 (1979) (*Bellotti (II)*).

[24]*Thornburgh*, 737 F.2d at 297. *But see* Brief for the United States, *supra* note 17, at 4-5.

[25]18 Pa. Cons. Stat. § 3214 (1983) (requiring information included the physician's name, location of facility, woman's age, race and marital status, type of abortion procedure, and any complications).

[26]*Id.* § 3211.

[27]*Thornburgh*, 737 F.2d at 301-02. *But see* Brief for the United States, *supra* note 17, at 9-10.

make available policies that excluded elective abortion coverage (except in the case of rape or incest). These policies would have been mandatorily priced less than policies with abortion coverage.[28] The appeals court invalidated this as an unjustified barrier to a woman's access to abortion.[29] We can be sure that insurance policies will also provide coverage for physician-assisted suicide (clearly a way to reduce the cost of care at the end of life) and we will all pay for it through our insurance premiums.

This Court's holding in *Thornburgh* had major substantive rulings regarding informed consent, reporting requirements, and regulations designed to preserve the lives of viable, aborted fetuses. It invalidated almost every regulation Pennsylvania had passed.

Second, in 1990, this Court decided the case of *Hodgson v. Minnesota*, 497 U.S. 417 (1990). This action was brought challenging the parental notification requirement of the Minnesota Abortion Law. In an eight part majority opinion with four opinions concurring in part and dissenting in part. Of three issues that reached this Court, one provision of the statute was struck down as unconstitutional, and two provisions were upheld. The issues concerned the abortion statute's 48-hour waiting period between notification of parents of minor's intent to obtain abortion and performance of that abortion, and the requirement that both parents be notified of a minor's intent to obtain an abortion.

And third, this Court, in 1992, decided the case of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992). Certain abortion clinics and a physician challenged the constitutionality of the 1988 and 1989 amendments to Pennsylvania's abortion statute. The United States District Court for the Eastern District of Pennsylvania held that several sections of the statute were unconstitutional. 744 F. Supp. 1323. The Court of Appeals for the Third District affirmed in part and reversed in

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[28]18 Pa. Cons. Stat. § 3215(e) (1983).

[29]*Thornburgh*, 737 F.2d at 303. *But see* Harris v. McRae, 448 U.S. 297, 316-17 (1980); Maher v. Roe, 432 U.S. 464, 474 (1977).

part. This Court affirmed in part, reversed in part, and held that: (1) the doctrine of stare decisis requires reaffirmance of *Roe v. Wade's* essential holding recognizing a woman's right to choose an abortion before fetal viability; (2) the undue burden test, rather than the trimester framework, should be used in evaluating abortion restrictions before viability; (3) the medical emergency definition in the Pennsylvania statute was sufficiently broad that it did not impose an undue burden; (4) the informed consent requirements, the 24-hour waiting period, parental consent provision, and the reporting and record-keeping requirements of the Pennsylvania statute did not impose an undue burden; and (5) the spousal notification provision imposed an undue burden and was invalid. Four concurring and dissenting opinions were filed. This undue burden test will no doubt be precedent for any constitutional right to assisted suicide.

These three decisions illustrate the complexity of abortion litigation and the fact that abortion safeguards have been repeatedly challenged and frequently struck down. If this Court recognizes a new constitutional right to assisted suicide, these cases will be precedent establishing physician-assisted suicide as a similar super protected right. The 9th Circuit already did so in its decision citing *Roe*, *Thornburgh*, *Webster*, and *Casey* in "defining [a] liberty interest [ ] identical to the approach used by the Supreme Court in the abortion cases." 79 F.3d at 801-03. It also declared, "In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. Casey in particular provides a powerful precedent." *Id.* "[T]he full scope of the liberty guaranteed by the Due Process Clause is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints." *Id.* at 803 (citing *Casey*, 505 U.S. at 848).

III. The Recognition of a Constitutional Right to Assisted Suicide Will Not Be Limited to Persons Who Are Terminally Ill and Mentally Competent.

The case law establishing a right to refuse life-sustaining medical treatment is binding precedent which will permit assisted

suicide for persons who are not terminally ill, and surrogate decisionmaking for persons who are incompetent, comatose, or in a persistent vegetative state. The 9th Circuit specifically included "the act of refusing or terminating unwanted medical treatment" within the liberty interest it was examining. 79 F.3d at 802. The act of refusing or terminating medical treatment is "subject to a balancing test that is less restrictive [than the compelling but narrowly tailored state interest], but nonetheless requires the state to overcome a substantial hurdle in justifying any significant impairment." *Id.* at 804. Further, the 9th Circuit based its decision squarely on *Cruzan*. *Id.* at 814-16.

However, if a right to assisted suicide is recognized, the right will not be limited to persons who are terminally ill and mentally competent. The 9th Circuit recognized this when it stated: "Our conclusion is strongly influenced by, but not limited to, the plight of mentally competent, terminally ill adults. We are influenced as well by the plight of others, such as those whose existence is reduced to a vegetative state or a permanent and irreversible state of unconsciousness." *Id.* at 816.

Although the 9th Circuit did not reach the equal protection issue (*id.* at 838), the 2d Circuit did. Based on *Cruzan* and other refusal/termination of medical treatment cases, it held that those persons not receiving life-sustaining treatment also have a right to hasten death, by physician-assisted suicide. *Quill v. Vacco*, 80 F.3d 716, 729 (2nd Cir. 1996). Thus, equal protection clause jurisprudence will no doubt require the recognition of a right to euthanasia (e.g. lethal injection) for those who cannot take a lethal dose by mouth, and a right to mercy killing for those who are incompetent, comatose, or in a persistent vegetative state or otherwise unable to exercise their constitutional rights to consent. Physician-assisted suicide will necessarily result in the legalization of euthanasia and mercy killing.

The jurisprudence of cases asserting a right to refuse medical treatment will provide the precedent. The right to refuse medical treatment has roots in both the common law right to be free from invasion of one's bodily integrity, and the notion of battery, which is a rejection of unwanted touching. *Schloendorff v. Society of New*

York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914). However, beginning in 1976 with *In re Quinlan* 70 N.J. 10, 335 A.2d 647, *cert. denied sub nom.* Garzer v. New Jersey, 429 U.S. 922 (1976) (when the New Jersey Supreme Court authorized the removal of a ventilator from Karen Ann Quinlan, who was in a coma), many courts have expanded this right by holding that the U.S. Constitution, through the right of privacy, guarantees to individuals a fundamental right to reject medical treatment, including medical treatment without which they will die. Some courts have explicitly characterized this as a "right to die." The following are several cases illustrating the breadth of the right to die since *Quinlan*. These are the precedents which will control any recognized right to determine the time and manner of death.

First, there are cases where competent persons who were terminally ill requested the right to refuse life support: *Tune v. Walter Reed Army Medical Hospital*, No. 85-0697 (D.D.C. Mar. 4, 1985) (held that competent adult patients with terminal illnesses have a right to determine for themselves whether or not they wish their lives to be prolonged by artificial life support systems).

Second, there are cases where competent persons who were disabled but not terminally ill and requested the right to refuse life-sustaining treatment or tube feeding: *Bouvia v. Superior Court*, 179 Cal. App. 3d 1127, 225 Cal. Rptr. 297 (1986) (held that no compelling state interest in the preservation of human life exists that would outweigh a competent but disabled person's right to terminate treatment because "the quality of her life has been diminished to the point of hopelessness, uselessness, unenjoyability and frustration." 225 Cal. Rptr. at 304);[30] *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (ratified the right to die for competent persons with disabilities who were dependent on life-sustaining treatment in order to live, e.g. those it described as having "an artificially extended life," "artificial survival," and an unchanging interest in hastening "natural death" for lives "irreparably

[30]Ms. Bouvia has quadriplegia due to cerebral palsy. She has not chosen to exercise her hard won right to die.

devastated by injury or illness.");[31] and *State v. McAfee*, 259 Ga. 579, 385 S.E.2d 651 (Ga. 1989) (upheld a lower court decision permitting Larry McAfee to shut off the ventilator that he had used since his accident. The trial judge had ruled that McAfee's right to refuse life-sustaining treatment outweighed the state's interest in preserving life and stated: "The ventilator to which he is attached is not prolonging his life; it is prolonging his death.").[32]

Third, there are cases where the persons are incompetent, but have previously expressed their wishes regarding the use of life-sustaining treatment: *Brophy v. New England Sinai Hospital, Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986) (held that casual remarks made by a patient prior to the onset of any illness could be sufficient evidence to find that the now incompetent patient would, if competent, decline to receive nutrition and hydration by tube);[33] *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) (upheld the state of Missouri's requirement that there be clear and convincing evidence that Nancy Cruzan previously decided to terminate her tube feeding in such circumstances as then existed, but did not require the clear and convincing standard be applicable in all states where removal of life-sustaining treatment and

[31]Kenneth Bergstedt was a thirty-one year old man with quadriplegia who died before the court's decision when his father, his primary caretaker, loosened the ventilator from his trachea after first administering Seconal and Valium. One week later, his father died from lung cancer. *Ailing Father Dies; Quadriplegic Had Ended Own Life for Fear Dad Would Go First*, San Diego Union, Oct. 12, 12,1990, at A27.

[32]*In re* McAfee, No. D-70960 (Super. Ct. Fulton County, Ga. Sept, 7, 1989). At the time, Larry McAfee was a thirty-four year old man with quadriplegia, after a sudden accident that left him disabled and on a ventilator. After joining the United Cerebral Palsy of Greater Birmingham, Georgia, he was trained in voice-activated computers and was employed in computerized design and drafting. He has not exercised his right to die. Applebome, *An Angry Man Fights to Die, Then Tests Life*, N.Y. Times, Feb. 7, 1990, at 1.

[33]Paul Brophy was forty-eight years old, unconscious or noncommunicative due to an aneurysm, but not terminally ill.

nutrition/hydration for incompetent patient was requested);[34] and *In re Browning*, 568 So.2d 4 (Fla. 1990) (authorized surrogates to withdraw life-sustaining treatment and tube feeding, without judicial approval, for incompetent patients who had previously expressed their wishes orally or in writing).[35]

Fourth, there are cases where termination of life-sustaining treatment was approved for persons who were incompetent and never previously expressed their wishes regarding the use of life-sustaining treatment: *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) (held that provision of tube feeding constitutes medical treatment that can be withheld from persons who are comatose upon the request of the family);[36] *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985) (held that a feeding tube could be removed at the request of a guardian based upon the patient's constitutional right of privacy and common law right to informed refusal of medical treatment);[37] *In re Jobes*, 108 N.J. 394, 529 A.2d 434 (1987) (held that a surrogate decisionmaker may withhold feeding by tube even when the incompetent patient has not left clear and convincing evidence of her intent);[38] and *In re Smerdon*, slip op. No. A-6031-89T1 (N.J. Super. Ct. App. Div. 1991) (held that a substitute judgment test should be applied when there is no clear and convincing evidence that the incompetent

[34]Nancy Cruzan was thirty-four years old, unconscious or noncommunicative due to an auto accident, but not terminally ill.

[35]Estelle Browning was ninety years old, incompetent due to a stroke, but conscious and communicative. She suffered from an incurable but not necessarily terminal illness. Her living will stated that tube feeding could be withheld or withdrawn if she was terminally ill and death was imminent.

[36]Clarence Herbert, the subject of this lawsuit, was fifty-five years old, comatose, but not terminally ill.

[37]Claire Conroy was eighty-three years old, incompetent but not comatose or in an unconscious state, and not terminally ill.

[38]Nancy Jobes was thirty-one years old, unconscious or noncommunicative due to an accident in surgery, but not terminally ill.

patient, while competent, wished to decline any medical treatment, including tube feeding).[39]

Fifth, there are cases where termination of life-sustaining treatment was approved for persons who had never been competent: *In re Sue Ann Lawrance*, 579 N.E.2d 32 (Ind. 1991) (held that the Indiana Health Care Act permits families to decide, in consultation with a physician, to withdraw life-sustaining treatment, including tube feeding, from never-competent patients in persistent vegetative state, without court approval, where there is unanimity among those with tangible personal or professional interest in the patient).[40]

And finally, there are cases where termination of life-sustaining treatment was approved for persons who were minors: *In re Swan*, 569 A.2d 1202 (Me. 1990) (held that pre-accident declarations made by a minor later left in a persistent vegetative state due to an accident may be found sufficient to satisfy a determination that clear and convincing evidence exists of the minor's decision to discontinue life-sustaining treatment and feeding tubes).[41]

Thus, based on the above decisions, the withdrawal of life-sustaining treatment includes withdrawal of life-sustaining treatment and tube feeding not only for those who are competent, terminally ill, and voluntarily electing to end their lives, but also persons who are comatose, in a persistent vegetative state, or otherwise incompetent, even those who were never competent including minors, whether they expressed their wishes prior to incompetency or not. Terminal illness is not required, only significant disabilities, or pain and suffering. For those who are

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[39]Theodore Smerdon was thirty-nine years old, unconscious and noncommunicative due to a stroke, but responded to pain, touch and smell, and was not terminally ill.

[40]Sue Ann Lawrance was forty-two years old, had never been competent due to mental retardation, was unconscious or noncommunicative due to a fall in 1987, but not terminally ill.

[41]Chad Swan was seventeen years old, unconscious or noncommunicative due to an automobile accident, but not terminally ill.

deemed competent, no psychological examination is required to determine if they are suffering from depression or other psychological disturbance. For those who are deemed incompetent, no clear and convincing evidence of their prior expressed wishes is required, only a surrogate's decision based on substituted judgment. In some states, no prior investigation, hearing, or approval by a court or other state official is required, only the unanimous agreement of family and physicians.

What was universally prohibited under traditional laws only a couple of decades ago, has now become commonplace, without significant safeguards for the patient, whether competent or not. Having achieved this level of casual disregard for human life, especially for those most vulnerable, we are now poised to leap from withdrawal of treatment and tube feeding in order to cause death, to the prescription of lethal doses, and under the equal protection doctrine as established in various precedents, the administration of lethal injections by syringe or intravenous line for those unable to take lethal doses by mouth.

If this Court opens the door of intentional killing by lethal dosing, there will be no effective safeguards for persons who are incompetent, especially persons who are mentally disabled with significant physical disabilities. The precedents cited above make it clear that any new constitutional right of assisted suicide will extend to persons who are not terminally ill, persons who are merely disabled and/or suffering physically, and persons who are comatose, in a persistent vegetative state, or otherwise incompetent.[42]

The question before this Court, although rather narrow in its present construction, is likely to impact the vast majority of the American people. Indeed, it will affect decisionmaking for everyone except those who are lucky enough to die quickly while in relatively good health and still living independently.

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[42]Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide—And Why These Are Not Convincing*, 12 Issues in Law & Med. 113, 129 (1996).

For these reasons it is clear that the recognition of a constitutional right to assisted suicide will not be limited to persons who are competent, terminally ill, and otherwise making a voluntary decision.

CONCLUSION

For the above reasons, your *amici* respectfully pray this Court (1) to hold that there is no right to assisted suicide in the Constitution of the United States, and (2) to reverse and/or vacate the decisions of the United States Courts of Appeals for the Second and Ninth Circuits.

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November 12, 1996

AMICUS CURIAE

BRIEF

(26) (33)

Nos. 96-110, 96-1858

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OCTOBER TERM, 1996

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HAROLD GLUCKSBERG, M.D., *et al.*,
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DENNIS C. VACCO, *et al.*,
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On Writs of Certiorari to the United States Courts of Appeals for the Ninth and Second Circuits

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BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

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28 pp

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	4
I. THERE IS NO CONSTITUTIONALLY-PROTECTED LIBERTY INTEREST IN PHYSICIAN-ASSISTED SUICIDE	4
A. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Has No Basis in the Text or Structure of the Constitution or in This Court's Precedents	4
B. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Is Not So Rooted in Our Traditions That It May Be Deemed "Fundamental"	9
C. States Have Compelling Reasons to Ban Physician-Assisted Suicide	12
II. THERE IS A RATIONAL BASIS FOR THE DISTINCTION BETWEEN ASSISTED SUICIDE AND THE REFUSAL OF MEDICAL TREATMENT	13
CONCLUSION	18

TABLE OF AUTHORITIES

CASES

	Page
Application of the President & Directors of Georgetown College, 331 F.2d 1000 (D.C. Cir. 1964)	17
Blackburn v. State, 23 Ohio St. 146 (1872)	11
Bouvia v. Superior Court, 225 Cal. Rptr. 297 (Cal. App. 1986)	17
Bowers v. Hardwick, 478 U.S. 186 (1986)	4, 8
City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985)	13
Collins v. City of Harker Heights, 503 U.S. 115 (1992)	5
Commonwealth v. Bowen, 13 Mass. 356 (1816)	11
Compassion in Dying v. State of Washington, 49 F.3d 586 (9th Cir. 1995)	7
Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996)	5, 6, 12
Compassion in Dying v. State of Washington, 85 F.3d 1440 (9th Cir. 1996)	8
Cruzan v. Missouri, 497 U.S. 261 (1990)	*passim*
Eichner v. Dillon, 426 N.Y.2d 517 (1980)	17
Gospodareck v. State, 666 So. 2d 835 (Ala. Crim. App. 1993)	10
In re Claire C. Conroy, 486 A.2d 1209 (N.J. 1985)	17
McKay v. Bergstedt, 801 P.2d 617 (Nev. 1990)	17
Michael H. v. Gerald D., 491 U.S. 110 (1989)	10
Moore v. City of East Cleveland, 431 U.S. 494 (1977)	3
Palko v. Connecticut, 302 U.S. 319 (1937)	3
People v. Matlock, 336 P.2d 505 (Cal. 1959)	10
People v. Roberts, 178 N.W. 690 (Mich. 1920)	11
Planned Parenthood v. Casey, 505 U.S. 833 (1992)	5, 7
Quill v. Vacco, 80 F.3d 716 (1996)	15
Roe v. Wade, 410 U.S. 113 (1973)	6, 8
Satz v. Perlmutter, 362 So. 2d 160 (Fla. App. 1978)	17
San Antonio Indep. Sch. Dist. v. Rodriquez, 411 U.S. 1 (1973)	13
Snyder v. Massachusetts, 291 U.S. 97 (1934)	9
State v. Bouse, 264 P.2d 800 (Ore. 1953)	11
State v. Cobb, 625 P.2d 1133 (Kan. 1981)	10

TABLE OF AUTHORITIES—Continued

	Page
State v. Fuller, 278 N.W.2d 756 (Neb. 1979)	10
State v. Mays, 307 S.E.2d 655 (W. Va. 1983)	10
Turner v. State, 108 S.W. 1139 (Tenn. 1907)	10

OTHER MATERIALS

Sir William Blackstone, *Commentaries on the Laws of England* (1769)	14
John Bouvier, Law Dictionary and Concise Encyclopedia (3d ed. 1914)	14
Daniel Callahan, *The Troubled Dream of Life: Living with Mortality* (1993)	16
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Sir Matthew Hale, 1 *Pleas of the Crown* (1847)	14
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Thomas J. Marzen, Mary K. O'Dowd, Daniel Crone & Thomas J. Balch, *Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1 (1985)	10
Alan Meisel, *The Right to Die* (1992 Supp.)	16
Model Penal Code and Commentaries § 210.5 (1980)	14
N.Y. Penal Law § 120.30 (McKinney 1987)	14
N.Y. Penal Law § 125.15 (McKinney 1987)	14
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Wharton's Criminal Law (Charles E. Torcia, ed. 1978)	10
E. Wingate, *Justice Revisited: Being the Whole Office of a County Justice of the Peace* (1661)	14

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BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF PETITIONERS

INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, the American Hospital Association ("AHA"), respectfully submits this brief in support of Petitioners in *State of Washington v. Glucksberg*, No. 96-110, and *Vacco v. Quill*, No. 96-1858.[1]

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[1] The AHA has the written consent of Petitioners and Respondents in both cases to the filing of this brief. Letters indicating their consent have been filed with the Clerk of the Court.

Founded in 1898, the AHA is the primary organization of hospitals in the United States. The AHA's mission is to advance the health of individuals and communities. AHA leads, represents, and serves health care provider organizations that are accountable to the community and committed to health improvement. Its membership includes 70% of the Nation's 5,000 hospitals, health systems, and other providers of care. Over 38,000 health care professionals hold individual memberships in the AHA.

The AHA has played a significant role in the ongoing debate concerning end-of-life decisions. It has worked vigorously through the legislative and judicial processes to help secure the right of patients, in consultation with their families and their physicians, to forego life-sustaining medical treatment.[2] And it regularly publishes policies and ethical guidelines addressing the roles of patients, families, guardians, physicians, and hospitals involved in termination-of-care decisions.

The AHA and its members have a vital interest in the outcome of *Glucksberg* and *Quill*. If a constitutional right to physician-assisted suicide is recognized, AHA members will be called upon to assist in the suicide of patients on a daily basis in hospitals across the country. In the view of the AHA, recognition of such a right would create an administrative nightmare for hospitals and other health-care providers as courts struggle to define the parameters of this new right. For this and other reasons described below, the AHA joins virtually every medical association and governmental panel to study the issue in opposing the creation of a constitutional right to physician-assisted suicide.

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[2] *See, e.g.*, Brief of the AHA as *Amicus Curiae*, in Support of Petitioners in *Cruzan v. Director of Missouri Dep't of Health*, No. 88-1503 (S. Ct. Sept. 1, 1989) (urging recognition of right to refuse medical treatment).

SUMMARY OF ARGUMENT

The American Hospital Association supports the right of every patient to choose whether or not to accept medical treatment. This right includes the right to forego even life-sustaining medical treatment, including artificially delivered food and water. Patients, in consultation with their families and their physicians, should be able to make such determinations free from government interference. The right of a patient to accept or reject medical treatment is in keeping with a doctor's well-recognized obligation not to force treatment on an unwilling patient. It is also consistent with this Court's precedents and with the deeply-rooted traditions of this country.

A right to physician-assisted suicide, by contrast, finds no basis in the text or structure of the Constitution or in this Court's precedents. Nor is such a right so "deeply rooted in this Nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), that it may be deemed "fundamental" or "implicit in the concept of ordered liberty," *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). To the contrary, physician-assisted suicide has long been illegal and continues to be so in the vast majority of states.

The American Hospital Association does not endorse state statutes criminalizing physician-assisted suicide. But the AHA cannot accept the assertion that the Constitution precludes such statutes. Under our system of government, democratically-elected officials should be able to grapple with this difficult issue free from "a background of federal constitutional imperatives that are unknown because they are being newly crafted from Term to Term." *Cruzan v. Missouri*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring). Hospitals, medical associations, individual physicians, and their patients and communities should all be able to take part in shaping public policy on this issue based on ethical, medical, and political considerations. The Constitution does not preempt such informed dialogue.

Accordingly, the AHA believes that the Ninth Circuit decision being reviewed by this Court is both wrong and profoundly damaging to our constitutional scheme. The AHA also believes that the Second Circuit erred in failing to recognize a rational distinction between assisted suicide and the right to refuse medical care, which the AHA has long-championed.

ARGUMENT

I. THERE IS NO CONSTITUTIONALLY-PROTECTED LIBERTY INTEREST IN PHYSICIAN-ASSISTED SUICIDE

A. A Constitutionally-Protected Liberty Interest in Physician-Assisted Suicide Has No Basis in the Text or Structure of the Constitution or in This Court's Precedents

This Court has been understandably reluctant in recent years to expand the range of substantive due process rights protected by, though not mentioned in, the Constitution.

> The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional laws having little or no cognizable roots in the language or design of the Constitution. That this is so was painfully demonstrated by the face-off between the Executive and the Court in the 1930's, which resulted in the repudiation of much of the substantive gloss that the Court had placed on the Due Process Clauses of the Fifth and Fourteenth Amendments. There should be, therefore, great resistance to expand the substantive reach of those Clauses, particularly if it requires redefining the category of rights deemed to be fundamental. Otherwise, the Judiciary necessarily takes to itself further authority to govern the country without express constitutional authority.

Bowers v. Hardwick, 478 U.S. 186, 194-95 (1986).

The Ninth Circuit does not suggest that there is any basis in the language or design of the Constitution for a right to physician-assisted suicide. Rather, the court of appeals attempts to base its decision on two prior decisions of this Court, neither of which will bear that weight. *See Compassion in Dying v. State of Washington*, 79 F.3d 790, 812-16 (9th Cir. 1996) (relying on *Cruzan* and *Planned Parenthood v. Casey*, 505 U.S. 833 (1992)).

In *Cruzan*, 497 U.S. at 278, the Court correctly recognized that its prior decisions supported "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment." At common law, every individual had a right to "bodily integrity," to be free of any physical intrusion without consent. Any unconsented to touching was a battery. Out of this right to be free of battery grew the doctrine of "informed consent" and its "logical corollary," which is that "the patient generally possesses the right not to consent, that is, to refuse treatment." *Id.* at 269-70. The right to refuse treatment was universally recognized in state law cases and in a series of Due Process Clause decisions leading up to *Cruzan*. *Id.* at 269-78.

In *Cruzan*, the Court assumed without deciding that "under the general holding of our cases, the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life, would implicate a competent person's liberty interest." *Id.* at 279. In other words, the Court assumed that the long-recognized right to refuse medical treatment includes the right to refuse even treatment necessary to sustain life. The Ninth Circuit has taken that assumption, which was well-grounded in the Court's precedents, and run with it into a wholly "uncharted area" where the "guideposts for responsible decisionmaking . . . are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992).

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In The

Supreme Court of the United States

October Term, 1996

STATE OF WASHINGTON, *et al.*,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

DENNIS C. VACCO, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

On Writ Of Certiorari
To The United States Courts Of Appeals
For The Ninth And Second Circuits

BRIEF OF AMICUS CURIAE RICHARD THOMPSON OAKLAND COUNTY PROSECUTING ATTORNEY IN SUPPORT OF PETITIONERS

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45 pp

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF THE AMICUS 1

SUMMARY OF THE ARGUMENT 6

ARGUMENT 7

I. THIS COURT SHOULD NOT RECOGNIZE A NEW CONSTITUTIONAL RIGHT TO DIE WITH THE ASSISTANCE OF A PHYSICIAN UNDER EITHER THE DUE PROCESS CLAUSE OR THE EQUAL PROTECTION CLAUSE WHERE SUCH A RIGHT IS NOT MENTIONED IN THE CONSTITUTION, HAS NO SUPPORT IN THE LEGAL HISTORY OF THIS NATION, IS NOT RECOGNIZED BY THE LAWS OF THE 50 STATES, AND IS INCAPABLE OF BEING CONFINED OR CONTROLLED BY SPECIFIC JUDICIAL OR LEGISLATIVE REGULATIONS. 7

CONCLUSION 30

TABLE OF AUTHORITIES

Page

CASES:

Boyd v *United States*, 116 U.S. 616 (1886) 3

In re Joseph G, 34 Cal. 3d 429; 667 P.2d 1176; 194 Cal. Rptr. 163 (1983) 26

People v *Burrel*, 253 Mich. 321; 235 N.W. 170 (1931) 24

People ex rel Oakland County Prosecuting Attorney v *Kevorkian*, 210 Mich. App. 601; 534 N.W.2d 172 (1995), lv. den. 451 Mich. 874; 549 N.W.2d 566 (1996), cert. den. ___ U.S. ___, (No. 96-135; Oct. 15, 1996) 5

People v *Kevorkian*, 447 Mich. 436; 527 N.W.2d 714 (1994), cert. den. ___ U.S. ___, 115 S. Ct. 1795, 131 L. Ed. 2d 723 (1995) 21

People v *Kevorkian No 1*, 205 Mich. App. 180; 534 N.W.2d 172 (1994) 21

United States v *12 200-ft Reels of Super 8mm Film*, 413 U.S. 123 (1973) 3

Vacco v *Quill*, 80 F.3d 716 (CA 2, 1996) 30

Washington v *Glucksberg*, 79 F.3d 709 (CA 9, 1996) 30

CONSTITUTIONAL AND STATUTORY AUTHORITY:

U.S. CONST. amend. XIV, § 1 1

MISCELLANEOUS:

D. Asch, M.D., *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New England J Med 1374 (1996) 19

M. Betzold, *Appointment with Dr. Death* (1993) 9

TABLE OF AUTHORITIES – Continued

Page

M. Betzold, *"Drop dead, Dr. K"*, The Detroit Sunday Journal, June 16, 1996 11

D. Callahan, *The Troubled Dream of Life* (1993) 3

D. Callahan & M. White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U Richmond L Rev 1 (1996) 13, 29

E. Chevlen, M.D., *Mock Medicine, Mock Law*, First Things (July, 1996) 27

R. Cohen, *"Patients can't tell their stories after their visits to Kevorkian,"* Detroit Free Press, June 30, 1996, 3E, col. 1 19

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Detroit Free Press, Sept. 12, 1996, 8B, col. 1 24

Detroit Free Press, Sept. 20, 1996, 1A, col. 2 23

Detroit Free Press, Oct. 31, 1996, 1A, col. 1 15

Detroit Free Press, Nov. 4, 1996, 1B, col. 2 ... 15, 16, 17

Detroit Free Press, Nov. 5, 1996, 1B, col. 2 24

R. Fenigsen, M.D., *Physician-Assisted Death in the Netherlands: Impact of Long-Term Care*, 11 Issues in Law & Medicine 283 (1995) 14

Y. Kamisar, *Physician-assisted suicide: the last bridge to active voluntary euthanasia*, in Euthanasia Examined (J. Keown ed. 1995) 2

Y. Kamisar, *When is there a Constitutional "Right to die"? When is there No Constitutional "Right to live"?*, 25 Georgia L Rev 1203 (1991) 4

TABLE OF AUTHORITIES – Continued

Page

Y. Kamisar, *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*, 42 Minn L Rev 969 (1958) 21

J. Kevorkian, M.D., *Prescription: Medicide – The Goodness of Planned Death* (1991) 8, 13, 20

T. Marzen, M. O'Dowd, D. Crone, & T. Balch, *Suicide: A Constitutional Right?*, 21 Duquesne L Rev 1 (1985) 26

"Post Mortem", People Magazine (September 16, 1996) 16

T. Quill, M.D., *Death and Dignity: Making Choices and Taking Charge* (1993) 12

Report of the New York State Task Force On Life And The Law, Executive Summary 27

C. Scanlon, R.N., *Euthanasia and Nursing Practice – Right Question, Wrong Answer*, 334 New England J Med 1401 (1996) 19

W. Smith, *Depressed? Don't Go See Dr. Kevorkian*, N. Y. Times, Sept. 16, 1995, at § 1, p. 19, col. 2 20

INTEREST OF THE AMICUS[1]

The Court of Appeals for the Ninth Circuit has discovered a constitutionally-protected liberty interest to medical assistance for a competent, terminally-ill, adult person who has chosen to commit suicide. This liberty interest is claimed as a component of the due process clause of the Fourteenth Amendment. The Court of Appeals for the Second Circuit has rejected this new constitutional right based on due process, but has held that a statute which precludes willing physicians from prescribing drugs to competent terminally-ill adults who wish to end their lives using these drugs violates the equal protection clause of the Fourteenth Amendment. U. S. CONST. amend XIV, § 1.

Petitioner State of Washington will explain how the Ninth Circuit erred in announcing a new constitutional right grounded in due process. Petitioner Vacco will explain how the Second Circuit erred in finding a violation of the equal protection clause. Numerous other amici will address associated concerns implicated by recognition of a new constitutional right to so-called physician-assisted suicide, or the "right to die with assistance."[2]

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[1] Letters of consent have been sent to the Clerk of the Court pursuant to Rule 37.3.

[2] Following the modern tenet that the first step in gaining public support for an idea is to identify the concept in the most positive manner, supporters of physician-assisted suicide generally identify the issue as "the right to choose the manner and time of one's death" or "the right of terminally-ill competent adults who are suffering unremitting and unremediable pain to choose when and how to end their suffering." In other words, they try to use a label which invokes a right to personal autonomy (*i.e.*, the "right to choose"). However, just as "a rose by any other name is still a rose,"

For example, the American Medical Association will be able to advise this Court of the impact on the medical profession which will result from recognition of a new constitutional right to die with physician assistance. Such a right would initiate a change in the traditional role of doctors as healers who are ethically sworn to "do no harm."

Moreover, in this day of escalating medical costs, debate over a national health care system, constant medical advances aimed toward prolonging life, and an aging population, there will inexorably be pressure on doctors, nurses, and relatives of terminally-ill patients to cut short nature's course. The patients themselves will also feel pressure to end their lives to save often scarce and limited family financial resources and to avoid being a burden on their loved ones.

Advocates for the physically or mentally disabled will be able to advise this Court of the pressure that recognition of such a right will put on disabled persons, who all too often are already marginalized or ignored by society.

Medical ethicists can inform this Court, as Daniel Callahan has written, that

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euthanasia by any other name is still euthanasia. In Y. Kamisar, *Physician-assisted suicide: the last bridge to active voluntary euthanasia*, in Euthanasia Examined (J. Keown ed. 1995), Professor Yale Kamisar observes at page 225: "Some 30 years ago an eminent constitutional law scholar, Charles L. Black, Jr., spoke of 'toiling uphill against that heaviest of all argumental weights – the weight of a slogan.' I am reminded of that observation when I confront the slogan the 'right to die.' Few rallying cries or slogans are more appealing and seductive than the 'right to die.' But few are more fuzzy, more misleading, or more misunderstood."

> [t]he proposal to legalize euthanasia and assisted suicide is nothing less than a proposal to add a new category of acceptable killing to those already socially legitimated. To do so would be to reverse the long-developing trend to limit the occasions of legally sanctioned killing (most notable in the campaigns to abolish capital punishment and to limit access to handguns). Civilized societies have slowly come to understand how virtually impossible it is to control even legally sanctioned killing. No matter how carefully safeguards are fashioned, abuse and corruption are invited.

D. Callahan, *The Troubled Dream of Life* (1993), pp 104-105.

Review of this Court's own writings will alert the Court that recognition of a new constitutional right to assisted suicide will start an inexorable process of enlargement of that initially limited and narrowly-defined right. As this Court stated in *United States v 12 200-ft Reels of Super 8mm Film*, 413 U.S. 123, 127 (1973):

> * * * The seductive plausibility of single steps in a chain of evolutionary development of a legal rule is often not perceived until a third, fourth, or fifth "logical" extension occurs. Each step, when taken, appeared a reasonable step in relation to that which preceded it, although the aggregate or end result is one that would never have been seriously considered in the first instance. This kind of gestative propensity calls for the "line drawing" familiar in the judicial, as in the legislative process: "this far but not beyond." * * * .

This Court also recognized this "seductive plausibility of single steps in a chain" in *Boyd v United States*, 116 U.S. 616, 635 (1886). Justice Bradley, writing for the majority, in response to the government's argument that compelling the defendants to turn over an invoice was an

inconsequential matter that didn't really implicate search and seizure concerns, cautioned:

> It may be that it is the obnoxious thing in its mildest and least repulsive form; but illegitimate and unconstitutional practices get their first footing in that way, namely, by silent approaches and slight deviations from legal modes of procedure. . . . [The Courts'] motto should be *obsta principiis*.

Or, as Professor Kamisar has observed in Y. Kamisar, *When is there a Constitutional "Right to die"? When is there No Constitutional "Right to live"?*, 25 Georgia L Rev 1203, 1227 (1991):

> However, what we cannot do – perhaps cannot even think about doing – in one step we are often able to do in two or three. Professor Schneider has called this "a psychological aspect of slippery slopes: they work partly by domesticating one idea [say, disconnecting the respirator] and thus making its nearest neighbor down the slope seem less extreme and unthinkable." [Footnote omitted.]

Both petitioners and amici can inform the Court of the certainty that recognition of a new constitutional right will inevitably start our society on a trip down that "slippery slope" by cutting off public debate, divesting the legislature of its power to regulate this question, putting the government's imprimatur of approval behind the broad concept of assisted suicide, and thus further acclimatizing the citizenry to the acceptability of that idea and thereby preparing them for further steps down the perilous slope.

However, only one amicus can address this Honorable Court from actual practical experience with the reality of assisted suicide: the Prosecutor of the County of Oakland who has attempted to prosecute the "poster

child" of the assisted suicide movement, Jack Kevorkian, for his role in the deaths of five individuals.

Altogether, by present count (the figure changes virtually day-to-day), Kevorkian has acknowledged being present at the suicides of 45 people. His attorney has further admitted that Kevorkian has assisted some undisclosed number of other "patients" to commit suicide. The majority of these deaths have occurred in Oakland County. Kevorkian resides in, and provides his suicide assistance, mainly in Oakland County. On October 29, 1996, Amicus petitioned for, and obtained, an order to show cause why Kevorkian should not be held in contempt for his alleged continuing violations of a permanent injunction issued by the Oakland County Circuit Court in 1991.[3] On October 31, 1996, Amicus filed new criminal charges against Kevorkian and his associates covering such activities as assisting in suicides, conspiracy, removing dead bodies without the permission of the medical examiner, holding himself out as a practicing physician while engaging in unlawful conduct, and possession of a controlled substance. Thus whatever decision this Honorable Court renders will have its greatest and most immediate impact on the Oakland County Prosecutor's Office.

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[3] This injunction was upheld by the Michigan Court of Appeals, leave to appeal has been denied by the Michigan Supreme Court, and on October 15, 1996, the United States Supreme Court denied Kevorkian's petition for writ of certiorari. *People ex rel Oakland County Prosecuting Attorney v Kevorkian*, 210 Mich. App. 601; 534 N.W.2d 172 (1995), lv. den. 451 Mich. 874; 549 N.W.2d 566 (1996), cert. den. ___ U.S. ___ (No. 96-135; Oct. 15, 1996)

SUMMARY OF ARGUMENT

The on-going campaign by Jack Kevorkian over the past six years to gain recognition for his right to assist people of his choosing to commit suicide has focused national attention on the issue of assisted suicide. Advocates of the practice have insisted that, despite overwhelming historical evidence to the contrary, assisted suicide is a constitutionally-protected right. Those opposed to the recognition of a new constitutional right have pointed not only to the historical and legal record, but also to concerns regarding inevitable abuses which will occur if this Court creates such a new constitutional right.

Amicus submits that the actions of Kevorkian in Oakland County, Michigan, clearly demonstrate that the fears of the opponents of assisted suicide are valid. In fact, virtually all of the arguments against assisted suicide can be illustrated by examination of the "patients" who have chosen to submit their lives to Kevorkian's care.

Kevorkian assists others to commit suicide based solely upon his own determination of whether their request for his assistance is rational. He does not require that they be terminally ill or in unremitting and unremediable pain. He requires only that they suffer from some real or imagined malady that has sufficiently interfered with their "quality of life" as to convince them that their life is not worth living. If they are able to make a request for his assistance in what appears to him to be a competent manner, then Kevorkian is all too ready to grant that request. He engages in a facade of performing a medical procedure with adequate safety checks, but in reality if his subjects are willing to have him assist them to commit suicide, then they invariably receive his assistance and

they die – whatever their true physical and mental condition.

Only by refusing to recognize a new constitutional right to die can this Court hope to prevent an incursion of more "Dr. Deaths" who will offer the sick, infirm, depressed, and aged only the siren song of a painless death.

ARGUMENT

THIS COURT SHOULD NOT RECOGNIZE A NEW CONSTITUTIONAL RIGHT TO DIE WITH THE ASSISTANCE OF A PHYSICIAN UNDER EITHER THE DUE PROCESS CLAUSE OR THE EQUAL PROTECTION CLAUSE WHERE SUCH A RIGHT IS NOT MENTIONED IN THE CONSTITUTION, HAS NO SUPPORT IN THE LEGAL HISTORY OF THIS NATION, IS NOT RECOGNIZED BY THE LAWS OF THE 50 STATES, AND IS INCAPABLE OF BEING CONFINED OR CONTROLLED BY SPECIFIC JUDICIAL OR LEGISLATIVE REGULATIONS.

In the person and practice of Kevorkian this Court can see revealed virtually all of the ills which inevitably afflict the concept of assisted suicide.

Supporters of assisted suicide claim that it would only be utilized by mentally competent adults who were terminally ill and/or suffering great and unremediable pain. Both the Ninth and Second Circuits have affirmed this supposedly "narrow" recognition of a new constitutional right.

Yet given the amorphous nature of the concepts of "terminal" illness and "pain," in actual practice the right could never be restricted only to the terminally ill who were suffering great pain. While some might view terminal illness as a sickness that is sure to kill within days, for

others terminal illness is simply a diagnosis that indicates to some degree of medical certainty that the person afflicted will inevitably die as a direct result of the disease – be it days, weeks, months, or years later. Similarly, what is great and unremitting pain to one person is a level of pain that can be stoically borne by another.

In actual practice such a new constitutional right could *never* be narrowly restricted. The experience amicus has had with Kevorkian bears this out.

In his book, *Prescription: Medicide – The Goodness of Planned Death* (1991), Kevorkian recalls discussing the possible use of his new invention, the "Mercitron" (an intravenous poison drip apparatus), with a potential initial recipient of his services:

> I had to make the patient understand why she was not a suitable candidate for the first use of the Mercitron. Even though she was terribly agonized by an intolerable "quality of life," her condition was not imminently terminal. In order to minimize the passionate (if irrational) storm of criticism certain to be evoked by such a procedure, I realized that ideally it should be in connection with a suffering and indisputably terminal patient – for example, someone dying of incurable and widespread cancer. I explained how that should blunt condemnation of my assisting her as the second case. * * * . [*Id.* at p 219.]

This woman eventually ceased contact with Kevorkian. However, subsequent events demonstrated that Kevorkian had set aside his fears of an "irrational storm of criticism" because none of his first three "test subjects" were terminally ill.

The first woman to meet her death with Kevorkian's active assistance was Janet Adkins, a 54-year-old wife and mother from Portland, Oregon, who was in the early

stages of Alzheimer's disease. She had no physical pain; indeed, she played tennis shortly before she traveled to Michigan to seek Kevorkian's aid in committing suicide. The plain evidence, supported by the autopsy, conclusively demonstrated that she could not even remotely have been considered terminally-ill or suffering from unremitting and intractable pain. In an interview conducted with Adkins before her death, Kevorkian himself states to Adkins' husband (in Adkins' presence): "Of course you realize that she is not terminal." M. Betzold *Appointment with Dr. Death,* (1993) at p 70. In response to Kevorkian's question, Janet Adkins admitted that she was not in pain. *Id.* at 69. Kevorkian acknowledged in a deposition taken on July 25, 1990, that he personally met Mrs. Adkins for the first time on June 2, 1990. (Tr. of deposition, p 13; App. 5-6) He interviewed her for approximately 40 minutes (while he video-taped the proceeding for posterity) and concluded that "there was enough evidence that she was mentally sound. She knew what she was doing." (Tr. of deposition, p 18; App. 6) Kevorkian admitted he did not physically examine Adkins and merely reviewed medical records that were almost a year old. (Tr. of deposition, pp 24-25; App. 6-7) When asked if Adkins might have been suffering from depression, Kevorkian responded: "Not to be depressed with Alzheimer's is abnormal."[4] (Tr. of deposition, p 27;

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[4] In his testimony before Circuit Judge Alice L. Gilbert in a case seeking a civil injunction, Dr. Kevorkian made the same assertion. When asked whether it was important for him to be able to recognize suicidal ideation in those he evaluated, Kevorkian responded: "Not if they have a crippling physical disease. I don't rely on mental problems. I rely on their physical disease, which then affects the mind. Anybody who's got a terrible crippling disease or terminal cancer and is not depressed is abnormal." (Tr. of June 8, 1990, pp 43-44; App. 3)

App. 7) On June 4, 1990, in the back of his rusty 1968 Volkswagen camper, Kevorkian attached his suicide apparatus to Mrs. Adkins' arm and stood by while she started a flow of poison into her body.

The second woman to whom Kevorkian provided his "services" was Sherry Miller, a 43-year-old woman who resided in Roseville, Michigan. Ms. Miller had multiple sclerosis, but was not terminally-ill and was not suffering physical pain. Dr. Ljubisa J. Dragovic, the Chief Medical Examiner for Oakland County, testified at the preliminary examination of Kevorkian (on charges arising from the deaths of Miller and Marjorie Wantz), that Miller was not in danger of imminent death as a result of multiple sclerosis, that the disease had not yet affected her heart, lungs, or gastrointestinal system, and that, considering the quality of her internal organs, "she had good chances of relatively long survival." (Tr. of February 15, 1992, 326-327; see App. 8-9) She had simply become tired of trying to cope with her diminishing physical ability, and, since she was single, did not want to burden others with her care.[5]

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[5] Sherry Miller testified at a proceeding in the Oakland County Circuit Court wherein the amicus sought (and ultimately obtained) an injunction against Kevorkian providing any assistance to individuals seeking to commit suicide. She repeatedly stated that she desired to commit suicide because she didn't want to be a burden to her family. For example, in response to questioning from Kevorkian's attorney concerning whether she felt she had a responsibility to her parents to remain alive, Ms. Miller responded: " . . . I don't think that's fair because I have to burden my parents with the responsibility of taking care of me. [I'm] Forty-two years old. They're getting older. No, it's not fair." (Oakland County Circuit Court case no. 90-390963 AZ, Tr. of January 8, 1991, p 155 – see App. 7-8.) Subsequently, when asked by the prosecutor when she first decided that she wanted to die, she answered: "That's a tough question. I mean, I knew when I had MS, you know, I didn't want to be a burden to anybody, and if I couldn't function as a human being, I didn't want to live. So, it's been quite some time." (Tr. of January 8, 1991, *supra*, at 169; App. 8.)

The third woman Kevorkian assisted was Marjorie Wantz, a 58-year-old woman from Sodus, Michigan. Mrs. Wantz claimed to have suffered great and unremitting vaginal pain for a period of years. She related this pain to what she claimed was botched surgery (as well as repeated attempts at corrective surgical intervention). At one point she was committed to a mental hospital because no physical source could be found to explain the pain of which she complained. Eventually she decided that she didn't want to live with this psycho-somatic pain any longer and she sought out Kevorkian. A complete autopsy following her death failed to show *any* physical cause for her pain. (Tr. of February 15, 1992, at 338-339; App. 9-10) Moreover, there was *no* question that Mrs. Wantz was *not* terminally-ill, even under the broadest possible definition of that term.

The vast majority of the 44 individuals Kevorkian has assisted to commit suicide were not terminally ill as that phrase is commonly understood – that is, persons having less than six months to live. Many of the people he assists to die continue to be individuals who appear to have simply decided they don't want to live anymore.[6] Two individuals have died after suffering from non-terminal emphysema. One woman had arthritis and osteoporosis. A recent patient/victim was depressed, overweight, and allegedly suffering from "chronic fatigue syndrome" and fibromyalgia. Prior to death she had made allegations of

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[6] M. Betzold, *"Drop dead, Dr. K"*, The Detroit Sunday Journal, June 16, 1996, p 1, col. 3.

spousal abuse against her husband, allegations which she subsequently sought to disavow. If those allegations were true, they cast serious question on her reasons for seeking to end her life. If they were false, they cast serious question on her mental competence in seeking death.

Once again, it can be expected that supporters of assisted suicide will argue that simply imposing more safeguards, or checks and balances, can alleviate any of the concerns arising from Kevorkian's unregulated practices. Practical experience shows that such optimistic assessments must be rejected.

If a complex system of safeguards is to be set up to attempt to regulate assisted suicide, establishment of such a system is a job for state legislatures, not a judicial function. Moreover, once this Court pronounces a limited right to assisted suicide under certain conditions, it has cut off public debate and interfered with the ability of the states to legislate effectively.

Supporters of assisted suicide maintain that with sufficiently stringent criteria and proper monitoring, the State could ensure that only competent, terminally-ill adults would receive the "benefit" of physician assistance to end their lives. However, practical experience demonstrates that it is naive to believe that the practice of assisted suicide, once legitimated even in a limited form, could be successfully restricted or regulated.

Estimates seem to vary, but a clear majority of states currently outlaw assisted suicide. Yet the fact that it is criminally actionable in most states has not dissuaded numerous doctors and nurses from quietly practicing either assisted suicide or out-right euthanasia, as the writings and practice of Respondent Quill show. See generally, T. Quill, M.D., *Death and Dignity: Making Choices and Taking Charge* (1993). Some people therefore argue

that, since it's being done anyway, why not simply legalize it under strict regulations and thereby control it? However, given that assisted suicide and euthanasia are being conducted in secret despite criminal bans, why should anyone but the most starry-eyed optimist believe that legalizing the practice under detailed regulations would serve to *control* the practice?

In their article *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U Richmond L Rev 1 (1996), authors Daniel Callahan and Margot White respond to the assertion that establishing specific rules and codes of practice will serve to bring the practice into the open and to control it:

> * * * If it is truly the case that the present statutes forbidding euthanasia and PAS [physician-assisted suicide] are widely ignored by physicians, why should we expect new statutes to be taken with greater moral and legal seriousness? There is no available survey or other evidence to indicate that new laws will bring increased commitment to following the law. [*Id.* at 5.]

Kevorkian has written that he was inspired to action by his trip to the Netherlands to study their experience with assisted death. *Prescription: Medicide, supra,* at 189-192. The Dutch experience with legalized euthanasia demonstrates the futility of believing that legalizing the practice under strict controls could result in an orderly process applied only to those who met stringent guidelines. Once the government approves of the practice – even the very *limited* practice that some have advocated – there would simply be *no* way to contain it. It would be like saying that we could tolerate just a little bit of the Ebola virus in our bodies.

Dr. Richard Fenigsen, who has extensively studied the experience in the Netherlands, has written of the way in which the practice expands organically in spite of specific procedures which are mandated by the government. Fenigsen notes that the Dutch have one of the best and most comprehensive health care systems of any industrialized nations. Nevertheless, despite this comprehensive care system, "the lives of many people are deliberately put to an end, and this happens sometimes upon the request of the person in question and sometimes without his or her request, consent, or knowledge." R. Fenigsen, M.D., *Physician-Assisted Death in the Netherlands: Impact of Long-Term Care*, 11 Issues in Law & Medicine 283 (1995). Looking to data for the year 1990, Fenigsen reports that out of 13,506 lives ended by withdrawing or withholding medical treatment with the intent to terminate life, 8,750 (or 64.78%) occurred *without* the patient's consent. Similarly, out of 11,800 individuals whose lives were ended through active euthanasia, 5,941 (or 50.35%) occurred *without* the patient's consent. Fenigsen further notes:

> The Report of the Government Committee confirmed that the lives of newborn babies with disabilities and of gravely ill children are also terminated, but no exact figures pertaining to these groups were obtained. However, an estimate of euthanasia on newborn babies and infants up to three months after birth was published by the Royal Dutch Society of Medicine in 1988. Annually, three hundred babies disabled due to extreme prematurity, birth trauma, spina bifida, or Down syndrome are starved and dehydrated to death or denied lifesaving surgery; ten babies with disabilities receive lethal injections each year.

> A Committee of the Royal Dutch Society of Medicine stated that termination of life of a newborn is justified if the child almost certainly would have an unliveable life. * * * .
>
> There may be disagreements between the persons who decide, but if the doctor and the parents agree on euthanasia, the life of the child will be terminated.
>
> According to the Royal Society's Committee, when the life of a disabled newborn is terminated, this should be done by refraining from lifesaving medical interventions and depriving the child of food and water; only when this is done and the child does not die, a lethal injection is justified. Again, the practice in some cases departs from the official advice, and doctors proceed directly to administering the lethal injections. *Id.* at 285-286; footnotes omitted.

The experience Amicus has had with Kevorkian firmly supports the above observations. An example which perhaps best illustrates the naiveté of believing that strict regulations can prevent abuse is the case of Rebecca Lou Badger. Kevorkian allegedly assisted Badger to commit suicide on July 9, 1996. Badger had been diagnosed with multiple sclerosis. However, an autopsy revealed no evidence of the disease. Detroit Free Press, Oct. 31, 1996, at 1A , col. 1; see also, Detroit Free Press, Nov. 4, 1996, at 1B, col. 2. In interviews that Badger had with the Merced County [California] Sheriff's Department, she claimed that her mother was pressuring her to commit suicide and "had twice provided her with narcotics" for that purpose. *Id.* The October 31, 1996, Detroit Free Press article goes on to report at page 12A:

> Friends and relatives interviewed in recent weeks described Rebecca Badger as an unreliable woman who often lied. But whether or not

her accusations against her mother are true, the events she described – some of which are confirmed by hospital records and police reports – reveal a disturbed and confused woman who vacillated between a desire to die and a fervent wish to live.

In response to such criticism, Kevorkian's attorney is reported to have responded to the Free Press reporter: "What's the point? I do not care if she thought Martians were coming after her." *Id.* Similarly, in an article titled "*Post Mortem*" in the September 16, 1996 issue of People Magazine at page 53, Kevorkian's attorney is reported to have asserted that Kevorkian merely relied on Badger's medical records when deciding that she was a suitable candidate for this service:

> "If they were wrong, then take the doctors' licenses away," [Geoffrey] Fieger fumes. "Don't criticize Jack. **He just accepted what they said**, and they said it repeatedly over the years." [*Id.* at 55; emphasis supplied.]

The article continues at page 55:

> * * * But the respected UCLA neurologist Dr. Louis Rosner, coauthor of the book *Multiple Sclerosis*, argues that since MS is often misdiagnosed, Kevorkian should have sought more opinions, "He accepts anything [patients] bring him as medical evidence," Rosner says, "and goes ahead with their wishes."

Badger's personal physician now says that she merely assumed Badger had MS because that was the diagnosis made by her neurologist. The neurologist now says that "his diagnosis was never conclusive" and that Badger could have suffered from Munchausen syndrome. Detroit Free Press, Nov. 4, 1996, *supra*, at 8B. It also appears that Badger was likely making continuing claims

of pain in an effort to obtain more pain relievers such as Vicodin, Demerol, and liquid morphine. *Id.*

According to the above article in People Magazine (and verified by a taped interview with Badger's daughter Christy Nichols, who was present when her mother died), Kevorkian's associate, Dr. Georges Reding interviewed Badger for between fifteen to thirty minutes immediately prior to the suicide itself to determine Badger's mental competence.[7] While Reding was conducting the *pro forma* interview, Kevorkian and his associate Neal Nicol were already setting up the apparatus and chemicals with which the deadly poisons would be introduced into Badger's body. See also Detroit Free Press, Nov. 4, 1996, *supra* at 8B.

Thus the case of Rebecca Badger tellingly reveals the way things will be if this Court recognizes a constitutional right to assisted suicide. Kevorkian followed the general outlines of the steps that most supporters of assisted suicide have argued would control the practice. He reviewed Badger's medical records. He interviewed Badger herself to determine if she was competent and if it

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[7] The involvement of Dr. Reding is clearly meant to stem criticism that has been leveled at Kevorkian based on the fact that he has no expertise in evaluating the mental status of his "patients." However, Dr. Reding is a vocal supporter of Kevorkian's campaign and cannot be expected to function as a neutral evaluator. As reported in the August 25, 1996, issue of the Dallas Morning News at p 1A, col. 1, Dr. Reding addressed a press gathering and stated: "I want to make sure that this word 'depression' is properly diagnosed and not mixed up with despair," Dr. Reding told the reporters. "People with a history of mental illness long before they become ill are one thing. But sick people despondent about their own suffering are another. In that case, their depression is rational and the antidote is not Prozac, but death."

was her considered choice to commit suicide. His associate, Dr. Reding, also interviewed Badger to assure that she was competent to make the decision to end her life. The key determination in their assessment was whether this was *her* considered choice. Since it was viewed from the perspective that the "patient's" right to personal autonomy was paramount, when Badger stated that she wanted to commit suicide, and she exhibited an objective basis grounded in her apparent medical condition for that decision, then Kevorkian and his associates merely acted to facilitate her assertion of her autonomous right.

Supporters generally speak in terms of *physician*-assisted suicide. Aside from the fact, as noted above, that this involves doctors in a realm that runs counter to their duty as healers, it elevates the practice of helping someone to kill themselves to a *medical procedure*. As Kevorkian's activities have clearly shown, assisting someone to kill themselves is *not* a medical procedure.[8]

Assisted suicide can be practiced in many forms. Kevorkian has utilized but two of the possible forms – carbon monoxide poisoning and injection of potassium chloride. The former can be administered by anyone – there is no need for a *doctor*.[9] Numerous *un*-assisted suicides occur each year from people who get into their cars in closed garages, start the engines, and drift off to death from carbon monoxide inhalation. Even injection of

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[8] In his testimony in the civil injunction case, Kevorkian acknowledged that his activities were not medically accepted and recognized procedures. Tr. of June 8, 1990, at 28; App. 1.

[9] Indeed, although still possessing a medical degree, Kevorkian's license to practice medicine has been suspended by both Michigan and California following his involvement in the Adkins death. This has not prevented him from continuing to assist others to commit suicide.

deadly drugs can be accomplished by other health professionals (such as nurses,[10] medical technologists, or physician assistants), by those who regularly self-inject medication (such as diabetics), or by virtually anyone who desires to study the technique and practice a little.

Furthermore, the right which doctors such as Respondent Timothy Quill have attempted to secure is the right to simply dispense oral prescription medicines to terminally-ill competent adults for them to utilize without active physician assistance to end their lives.[11] Such assistance may be provided by anyone licensed to dispense controlled substances. Once the right to die with assistance is recognized, how could it be limited to medical doctors when the procedure itself is not a medical procedure and no particular medical training is necessary in order to administer it?

Columnist Richard Cohen has written in his nationally-syndicated column (reprinted in the Detroit Free Press, June 30, 1996, at 3E, col. 1, *"Patient's can't tell their stories after their visits to Kevorkian"*):

> Why, I ask myself, can a woman be driven several hundred miles to see Dr. Jack Kevorkian but cannot be placed in the same car within her own closed garage and commit suicide within a step or two of her own home?
>
> The answer, I conclude, is not that the act of suicide is physically beyond her; it's rather that

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[10] See, D. Asch, M.D., *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New England J Med 1374 (1996), at pp 1374-1379 and C. Scanlon, R.N., *Euthanasia and Nursing Practice – Right Question, Wrong Answer*, 334 New England J Med 1401 (1996), at pp 1401-1402.

[11] In other words, an exception is sought with regard to stringent controls that are placed on a doctor's ability to prescribe and dispense controlled substances to the public.

she needs a facilitator. This is where Kevorkian comes in. The road to his clinic is a one-way street.

Kevorkian is a retired pathologist whose training and experience consists largely of examining corpses rather than in counseling live patients. He has no formal expertise in psychiatry or psychology. (Testimony of Jack Kevorkian, Tr. of June 8, 1990, 41-42; App. 2-3) Although he claims in his writings that he consulted with the personal physicians of his subjects, he sought no independent second opinions. In fact, he frequently ignored the opinions of those medical professionals who had been counseling, treating, or assisting the decedents.[12] He also ignored the physical evidence in front of him.[13]

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[12] As Kevorkian writes in *Prescription: Medicide, supra* at 222:

> I then telephoned Janet's [Adkins'] doctor in Seattle. He opposed her planned action and the concept of assisted suicide in general. **It was his firm opinion that Janet would remain mentally competent for at least one year (but from Ron's [Janet's husband's] narrative I concluded that her doctor's opinion was wrong and that time was of the essence).** Because Janet's condition was deteriorating and there was nothing else that might help arrest it, I decided to accept her as the first candidate – a qualified, justifiable candidate if not "ideal" – and well aware of the vulnerability to criticism of picayune and overly emotional critics. [Emphasis supplied.]

[13] In an op-ed column (W. Smith, *Depressed? Don't Go See Dr. Kevorkian*, N. Y. Times, Sept. 16, 1995, at § 1, p. 19, col. 2), Wesley J. Smith quotes Dr. Randolph B. Schiffer, an advisor to the National Multiple Sclerosis Society, as follows:

Kevorkian is answerable only to himself. Not only does he ignore the law, he taunts and belittles those who would enforce it against him. The Michigan Court of Appeals and the Michigan Supreme Court have upheld both a temporary state statute forbidding assistance in a suicide and the continued validity of the State's common-law prohibition against assisting a suicide. *People v Kevorkian*, 447 Mich. 436; 527 N.W.2d 714 (1994), cert. den. ___ U.S. ___; 115 S. Ct. 1795; 131 L. Ed. 2d 723 (1995); *People v Kevorkian No 1*, 205 Mich. App. 180; 534 N.W.2d 172 (1994). Nevertheless, Kevorkian has not only convinced three juries to ignore the law,[14] he has continued

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> "If a patient with multiple sclerosis has bed sores, it means by definition that, for whatever reason, he or she is not receiving adequate medical care."

Smith goes on to observe:

> Last month, Esther Cohan, who was 46 years old, committed suicide with the help of Jack Kevorkian. Ms. Cohan, who had multiple sclerosis, was disabled but not terminally ill. Esther's sister told reporters that her sister's body was covered with bed sores. Yet, according to Jack Kevorkian's lawyer, Geoffrey Feiger, Dr. Kevorkian had been "counseling" Ms. Cohan since March. Didn't he know that he was participating in the suicide of someone who, by Dr. Schiffer's standards, appears to have received inadequate care?

[14] Professor Yale Kamisar of the University of Michigan has noted the increased incidence of jury nullification associated with cases involving "mercy killing" in the 1940's and 1950's. Y. Kamisar, *Some Non-Religious Views Against Proposed 'Mercy-Killing' Legislation*, 42 Minn L Rev 969, 971-973 (1958). His observations have been proven to apply equally to physician-assisted suicide. Kevorkian has been tried three times (once in Wayne County, Michigan, and twice in Oakland County, Michigan, involving a total of five patients/victims) and has

to violate the law and publicly boast of his transgressions.

Practical legal problems beyond the specter of jury nullification have already arisen in this area, as the experience of amicus has shown. Kevorkian initially announced his participation in the assisted suicides of his "patients." He would personally alert the police to the deaths. He was present when the police arrived and made statements to them. Evidence associated with the administration of the poisons (i.e., intravenous solutions, tubing, needles, carbon monoxide canisters, regulators, tubing, masks) was still present at the scene. Subsequently, when criminal charges were filed, he changed his practice. First, he would still contact the police, but when they arrived at the location of the suicide (often his Royal Oak apartment), the evidence associated with the suicide would have been removed. While he would make no statements to the police, his attorneys would subsequently call press conferences to announce Kevorkian's "attendance" at a suicide and to give details (often incorrect) of the deceased's medical background. Lately, Kevorkian has taken to simply dropping the body off at the medical examiner's office or at a local hospital, providing a few sketchy personal details about the deceased, and then leaving.

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been acquitted by the juries in each case. In each case there was clear and abundant evidence that Kevorkian actively assisted the decedents to commit suicide by providing the poison and the poison-dispensing apparatus and by hooking the decedents up to the apparatus. The defense did not dispute that he had done so. Nevertheless, in each instance the jury has seen fit to respond to Kevorkian's claim that he did not intend that the decedents should die, but rather that he only wished to relieve their pain and suffering.

Thus, Kevorkian continues to ignore the law while making it practically impossible to investigate or prosecute him. Since no one outside the immediate circle of participants knows for certain where the deaths occur, venue is difficult to establish.[15] Since the bodies are dropped off at the medical examiner's office or at hospitals, none of the paraphernalia associated with the "suicide" can be examined or seized. Those who are present at the death are either not identified, or, if their names are mentioned at a Kevorkian press conference, they refuse to cooperate with investigations by law enforcement.[16] In

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[15] Kevorkian's flamboyant attorney used this fact as a legal stratagem in a case tried in Wayne County. The body of Thomas W. Hyde, Jr. was found in Defendant's battered VW bus on Belle Isle, an island park in the Detroit River located in Wayne County. At trial, Kevorkian's attorney insisted that the death itself had actually occurred in Royal Oak – Oakland County, Michigan – and argued to the jury that they couldn't convict because venue (a necessary element) hadn't been established in Wayne County.

[16] An article appearing in the September 20, 1996 edition of the Detroit Free Press described how evidence obtained when police interrupted a Kevorkian "consultation" appeared to indicate that Kevorkian had assisted a 54-year-old Ionia, Michigan, woman who had multiple sclerosis to commit suicide. According to the article, a videotape seized by police depicts Kevorkian telling "an Ionia man how to mislead authorities about the cause of his wife's death". When questioned about this, Kevorkian's attorney responded: "I would urge all the families involved to tell the police that their loved ones went to Disneyland and fell off the mouse ride." A family physician had filled out the death certificate and attributed the death to natural causes resulting from multiple sclerosis. The body was then cremated. However, evidence of the woman's pre-death condition clearly suggested that she was not in a terminal condition. Detroit Free Press, Sept. 20, 1996, at 1A, col 2. Kevorkian's attorney has announced that there are others in

fact, when the police have subsequently contacted these individuals, they have refused to cooperate and referred the police to Kevorkian's attorney. The police and prosecutors have no way of compelling those witnesses to give information if they do not want to cooperate. Kevorkian's attorneys have routinely claimed to represent all the witnesses and have asserted their Fifth Amendment right not to incriminate themselves. Thus the public is left only with the self-serving statements of Kevorkian's attorneys describing what has occurred and the medical condition of the patient before his or her death.

Another legal obstacle to any effective regulation of assisted suicide is the venerated legal principle that mere presence at the scene of the crime is not itself a crime. *People v Burrel*, 253 Mich. 321, 323; 235 N.W. 170 (1931). That is why Kevorkian can stand in front of television cameras and state with impunity, "I was present at another assisted suicide." In that way Kevorkian takes credit for thumbing his nose at the law with no real risk to himself. Moreover, any comments his attorney makes cannot be used as evidence against Kevorkian.

If a right to physician-assisted suicide is recognized, regardless of how limited the right or how carefully we craft guidelines to prevent abuses, experience shows us there is no effective way to insure compliance with those guidelines and guarantee that significant abuses will not occur.

Michigan who have received Kevorkian's assistance in ending their lives, but whose names have not been, and will not be, released. *Id.* at 8A, col. 1 and Detroit Free Press, Sept. 12, 1996, 8B, col 1. On November 4, 1996, Kevorkian finally admitted that he had been present in Ionia at the death of Loretta Peabody. Detroit Free Press, Nov. 5, 1996, 1B, col. 2.

Police investigations into suspicious cases will be hindered by invocation of the physician-patient privilege.[17] The physician and patient's family control all of the information. Assisted suicide, by its nature, is a private matter between physician and patient. Decisions about suicide are made in private and the action itself is taken in private. Since we cannot place a police officer in every doctor's office, there is no practical way of knowing what the doctor and patient are going to do or what they have done. After death there is no practical way to determine whether the decision to commit suicide was voluntarily made, without subtle pressure or manipulation. A "conspiracy of silence" will develop since the "patient" will be dead and the physician will be able to invoke the privilege as a means of avoiding any questioning. Callahan and White, *supra*, at 8.

Furthermore, the physician-patient privilege would prevent law enforcement personnel from knowing the patient's plans for death or from obtaining medical records to determine the true medical condition of the patient. The physician-patient privilege continues after death and thus, even after the suicide has occurred, there is no way in which the truth of the suicide's condition can be determined. Practical experience in Michigan has

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[17] While acknowledging in his in-court testimony on June 8, 1990, that his use of the "suicide machine" with Janet Adkins was not a medically recognized and accepted procedure [Tr. of June 8, 1990, at p 28; App. 1], he claimed in his deposition testimony that his interview with Adkins was privileged because it was a medical consultation between a patient and her physician. [Tr. of July 25, 1990, at 8-9; App. 4-5.] Kevorkian's attorneys subsequently raised the physician-patient privilege as a barrier to turning over routine discovery during Kevorkian's criminal trials.

shown that this concern is very justified. As noted, Kevorkian has counseled "patients" and their families and friends to decline to cooperate with police investigations. See fn 16, *supra*. He has also apparently participated in one or more assisted suicides which have been covered up.

And what of the mental competency of the individuals who have surrendered themselves to Kevorkian's "tender ministrations"? Case law recognizes that one of the main reasons suicide itself was de-criminalized is that people who desired to commit suicide were generally considered to be mentally disturbed. T. Marzen, M. O'Dowd, D. Crone, & T. Balch, *Suicide: A Constitutional Right?*, 21 Duquesne L Rev 1, 63, 69 and n 467, 85-86, 88-89 (1985); *In re Joseph G*, 34 Cal. 3d 429, 433; 667 P.2d 1176; 194 Cal. Rptr. 163 (1983). As noted previously, Kevorkian's second "patient", Marjorie Wantz, had previously been committed to a mental hospital. Judith Curren was despondent over her weight, her "chronic fatigue syndrome", and, perhaps, her marital situation. Rebecca Badger had a history of alcoholism, an apparent addiction to pain medication, vacillated on the question of whether she wanted to die or whether she was being pressured to do so by her mother, and is now said by her neurologist to have possibly suffered from Munchausen's syndrome. Kevorkian's response is that the mental condition is irrelevant as long as the "patient" has some physical malady and knowingly requests his assistance to die. Tr. of June 8, 1990, at 40, 44-45; App. 3-4.

More significantly with respect to most potential "patients," however, is the fact that studies have shown that most individuals who express interest in committing suicide are suffering from depression – often arising out

of their condition or the absence of a support system – and that when the depression is treated, the desire to commit suicide disappears. See, *e.g.*, Report of the New York State Task Force On Life And The Law, Executive Summary, p x.[18]

In an article titled, *"Mock Medicine, Mock Law"* in the June/July 1996 issue of the journal First Things, Dr. Eric M. Chevlen, the Director of Palliative Care at St. Elizabeth Health Center in Youngstown, Ohio, (and a prosecution witness in both of the Oakland County criminal trials) has written of watching a Kevorkian-produced videotape of an interview with a "patient":

> The videotape seemed to be filmed in a cheap hotel room. It showed a man with advanced myeloma (bone cancer) asking for assistance in suicide. He appeared to be a textbook example of depression in the face of medical illness and inadequately treated pain: the flat voice, the lack of eye contact, the moving description of how life no longer yielded any pleasure, and even the veiled contempt he expressed for his own disability. I have seen many such patients in my career. In every case, the request for suicide was a symptom of depression, a treatable complication of cancer. In every case, proper treatment of the patient's pain, accompanied by emotional support and occasionally antidepressants resulted in reversal

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[18] The Report summarizes: "Contrary to what many believe, the vast majority of individuals who are terminally ill or facing severe pain or disability are not suicidal. Moreover, terminally ill patients who do desire suicide or euthanasia often suffer from a treatable mental disorder, most commonly depression. When these patients receive appropriate treatment for depression, they usually abandon the wish to commit suicide."

of the wish to be killed. As I watched the interview, I felt like shouting at the eerily jovial "doctor" on the screen, "He's depressed, you idiot! Treat him, don't kill him!"

But of course I knew that only a few hours after the videotape was made the myeloma patient had joined the long list of those who had died "in the presence of" Jack Kevorkian.

The encounter between Kevorkian and his victim was a simulacrum of a genuine medical interview. When Kevorkian asked the victim whether or not he had been experiencing pain, it was not with the intent to find a better medicine to treat it. It was to justify the use of the carbon monoxide he had obtained even before meeting him. When Kevorkian asked about the victim's anguish and wish to die, it was not to assess or relieve the obvious depression. It was to document that his "assistance" was given only with the victim's consent. [*Id.* at 17.]

Additionally, in light of the delays that have occurred while the issue of assisted suicide was appealed in the Michigan courts, in light of the successful public relations campaign Kevorkian has conducted, in light of the inability of law enforcement to either stop the practice, issue charges in pending open investigations, or to secure convictions following three separate trials, public opinion and blatant defense appeals to jury nullification have made it increasingly difficult or impossible to obtain a jury that will follow the law.

In fact, given that judges in Michigan are elected, it is not surprising that many judges facing re-election (and with an eye on the public opinion polls) find it difficult to divorce their personal opinions on the issue from their legal duty to follow the law. This reality will work to discourage active investigation by the police or serious

efforts to prosecute by the local prosecutors. Already the candidates for Oakland County Prosecutor from both political parties have publicly indicated that they will not prosecute Kevorkian under the Michigan common-law prohibition recognized by the Michigan Supreme Court, and have further indicated reluctance to institute any prosecutions even if the Michigan Legislature enacts a specific statutory prohibition.

In *Legalization of Physician-Assisted Suicide, supra,* at 5-6, Callahan and White observe:

> * * * Nor are there any surveys or other available evidence to suggest that prosecutors will show more zeal with new laws than with the old ones, or that juries will display less sympathy for violation of the new rules than they have for those who transgressed the old rules. It is, in short, very odd to claim that physicians who now do as they please, with complete de facto immunity from prosecution, will act differently with new laws, and that the new laws will be more stringently enforced. [Footnote omitted.]

A strong and clear judicial response that unequivocally states that the Constitution does not contain a right to assisted suicide would go far toward influencing public attitudes and putting the lie to the claim voiced by Kevorkian and his supporters that he is only doing that which is protected by the Constitution. It would alleviate the confusion which has arisen as a result of the conflict between the decisions of the Ninth and Second Circuits striking down bans on assisted suicide and the decisions of state courts which have upheld such bans. It would also place this serious and troubling issue into the proper forum – the state legislatures where the people's elected representatives can debate and grapple with a solution, or the ballot initiative alternative where the people can

directly vote on the issue. It is only by refusing to recognize a new and uncontrollable constitutional right to have the assistance of another person to commit suicide that this Honorable Court can ultimately protect the rights of those who would inevitably become victims of the seductive "right to die."

CONCLUSION

WHEREFORE, Amicus Richard Thompson, Prosecuting Attorney in and for the County of Oakland, respectfully requests this Honorable Court to reverse the decisions of the Ninth and Second Circuits in *Washington v Glucksberg*, 79 F.3d 709 (CA 9, 1996) and *Vacco v Quill*, 80 F.3d 716 (CA 2, 1996).

Respectfully submitted,

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APPENDIX

Excerpts from testimony of Jack Kevorkian in Oakland County Circuit Court in case no. 90-390963 AZ, June 8, 1990

Page 28:

Q [By Ass't Prosecutor] Doctor, would you say your use of the machine with Janet Adkins was in fact a medically accepted and recognized procedure?

A [By Jack Kevorkian] Not at all.

Q You in fact admit that it is not?

A It is not an acceptable practice; that's obvious.

Pages 40-41:

Q [By Ass't Prosecutor] And yet you're saying that you have to decide whether someone is worthy of your machine or not, so –

A Based on my medical expertise, not morality. My morality doesn't enter this. You don't know what my morality is. You haven't asked me that. But my medical expertise is the basis. There are five – may I go on with this and explain it briefly? There are five – I've come to this conclusion. I must – understand that it's not egotistical when I say, "I've done this, I've done that." Nobody helps me. I've got to do it. There are five criteria. Two with the patient: the patient's needs and the patient's wishes. Two. You take these into consideration. From the doctor: His medical expertise; his common sense; and his logic. Three. Now, these last

two are lacking in many doctors. Common sense and logic. The expertise he has. Everyone has that. We know that. They're pretty much equal.

Now, a good doctor would put these all together, and his expertise is the cardinal point. That's why ethicists don't belong in this decision. The doctor can philosophize as well as any theologian can, but a theologian can't know medicine like a doctor. It takes training and experience.

So, based on these five criteria – I wish it could be a group of doctors pooling this, without any extraneous ethicists – he comes to a decision with the cardinal point being medical expertise. Is the patient's wish and desire worthy of having this option granted?

Pages 41-42:

THE COURT: Excuse me, Doctor, but what is you medical expertise?

THE WITNESS [Jack Kevorkian]: Mine is limited, and that's why I say I want to pool, but they won't come forward –

THE COURT: No, no –

THE WITNESS: A pathologist, certified pathologist.

THE COURT: Are you licensed to practice pathology –

THE WITNESS: Licensed in Michigan and California – in California and Michigan, licensed to practice, yes, your Honor.

THE COURT: Do you have any other licensures in some –

THE WITNESS: No, just those two states.

THE COURT: Just those two states, both for pathology only.

THE WITNESS: No, for medical doctor. I could open an office if I want. I could help with surgery. I could treat any disease I want. Medical licensure allows one to do anything in medicine.

THE COURT: But you said expertise. Are you –

THE WITNESS: My specialty expertise is pathology, right.

Pages 43-44:

Q [By Ass't Prosecutor] Well, Doctor, don't you think that suicidal ideation would be an important thing that you would have to know before you deal with people who are asking to be put to death?

A Not if they have a crippling physical disease. Suicidal ideation is a mental problem. I don't rely on mental problems. I rely on their physical disease, which then affects their mind. Anybody who's got a terrible crippling disease or terminal cancer and is not depressed is abnormal.

Pages 44-45:

Q [By Ass't Prosecutor] Doctor, so in other words, you really don't care what the person's mental state is, if they in fact have a crippling disease and they say they want to die?

A Well, of course, I care. But the cardinal point is the physical disease. Is a physical disease enough to account for the mental state of the

patient? I said it's a grey zone. But in the case of David Rivlin last year, everybody who saw him said he should die, except a couple of religious fanatics. Now, would it take a great amount of medical expertise to decide that? If nothing else, establish this policy for that kind of case where everybody who looks at it says, "Yes." Even if it doesn't take a doctor.

Excerpts from Deposition of Jack Kevorkian in Oakland County Circuit Court case no. 90-390963 AZ, July 25, 1990

Pages 7-9

Q [By Ass't Prosecutor] As I understand it, when the state police officers contacted you as to being able to see a videotape they understood was available with your meeting of Mrs. Adkins on June 2nd –

A [By Jack Kevorkian] Uh-huh.

Q – you indicated you would not let them see it. Is that correct?

A That's true.

Q And you indicated there was going to be certain ground rules as to who could see that tape?

A Yes, but I didn't spell out the ground rules in detail.

Q Weren't they, in fact, the same ground rules that were in line with the consent to videotape that Janet Adkins prepared?

A That was part of it.

Q So, in other words, in this form where it states, (Reading) " . . . that said videotape or

motion picture be made available on a non-profit basis for viewing only by professional medical personnel, legislators, and judicial and other duly empowered authorities directly concerned with the promulgation and creation of the laws, rules, regulations, and ethical guidelines in connection with doctor-assisted suicide, with active euthanasia, or with judicial execution involving some kind of direct medical action and/or pharmaceutical drug."

Are you saying there were others?

A Yes, at that time I should have, I should have remembered – this was a medical consultation. It's privileged.

Q I'm sorry, where does it say that?

A It should have said that. That's an oversight.

Q And it doesn't say that?

A That's right.

Q If you're going –

A I realized later it's medical privilege between a patient and doctor.

Q When did you realize that?

A Later.

Q When's later.

A I cannot recall, but it was after this.

Page 13:

Q [By Ass't Prosecutor] Okay. And at this point in time had you, in fact, been retained as her doctor?

A [By Jack Kevorkian] When she contacted me I was retained as her doctor, yes.

Q When did they contact you?

A Her husband actually contacted me for her and she, I assume, she became my patient when I met her on June two.

Q That's the first time you had any contact with her?

A That's the first time I had direct contact with her personally.

Page 18:

Q [By Ass't Prosecutor] Okay. How long was the videotape?

A [By Jack Kevorkian] It's about 40 minutes.

Q And how was it finally concluded?

A I had come, I concluded that there was enough evidence that she was mentally sound. She knew what she was doing.

Pages 24-25

Q [By Ass't Prosecutor] At the time prior to the videotaping, did you physically examine Janet Adkins?

A [By Jack Kevorkian] No.

Q Did you take her heart rate?

A No.

Q Listened to her heart?

A No.

Q Did you even bring a stethoscope?

A No.

Q No physical evaluation at all?

A No.

Q Why is that?

A Her doctors had done all that. I had the records. Also it's a mental disease, not physical.

Q The records, as I understand it, were from the previous year; isn't that correct?

A It's a mental disease, not physical. You all know it's not physical. It's an attack that's being used for a criticism of what I did.

Page 27:

Q [By Ass't Prosecutor] What if she was suffering from depression?

A Not to be depressed with Alzheimer's is abnormal.

Q Okay. The fact that a depression might have caused her to want to possibly commit suicide, wouldn't matter to you?

A A person can be rational and depressed and can make a rational decision.

Excerpts from testimony of Sherry Miller in Oakland County Circuit Court, case no. 90-390963 AZ, January 8, 1991

Page 155:

Q [By Kevorkian's attorney] Don't you have a responsibility to your parents to allow them to continue to take care of you?

A [By Sherry Miller] No, I'm going to say – yeah, I don't think that's fair because I have to burden my parents with the responsibility of taking care of me. Forty-two years old. They're getting older. No, it's not fair.

Page 169:

Q [By Ass't Prosecutor] Now, when is it that you first decided that you wanted to die?

A That's a tough question. I mean, I knew when I had MS, you know, I didn't want to be a burden to anybody, and if I couldn't function as a human being, I didn't want to live. So, it's been quite some time.

Excerpts from preliminary examination testimony of Dr. Ljubisa J. Dragovic in 52/3 District Court, case no. 92-115190 FC, February 15, 1992

Pages 326-327:

Q [By Ass't Prosecutor] Okay. Was Sherry Miller in danger of imminent death as a result of this multiple sclerosis?

A [By Dr. Dragovic] No.

Q Had it had any effect on her heart?

A No.

Q Her lungs?

A No.

Q Her gastrointestinal system?

A No.

Q Given the fact of her physical condition, and the condition of her heart and lungs and the

rest of her body, could you project a period of time where she would continue to live and not be in danger of death?

A That's for the Almighty to decide, really, in every one of us. But based on the evidence that was present, the examination of – her internal examination – there was no suggestion that she was in any acute phase of the disease that would have threatened her life in a matter of days or even weeks, for that matter.

For comparison – and it might sound parodoxical, she was talking about whether she was quote/unquote, terminal, she was no more terminal than, let's say Magic Johnson.

Pages 338-339:

Q [By Ass't Prosecutor] Did you examine the tissue to where would there be any sort of unremitting pain for Mrs. Wantz?

A [By Dr. Dragovic] I did not find any anatomical evidence that would have suggested itself as a source of pain there, in the genito urinary system, nor in the gastro intestinal system, for that matter.

Q Did you take any further steps to determine any source of pain there?

A All that I examined, including the sacral dorsal root ganglia that I removed together with the spinal cord, did not show evidence of structural abnormality.

Q If there's no structural source for the pain, and a person was feeling pain, Doctor, where would that pain be coming from?

A Without evidence of source of pain in that area, then pain would be generally central in character and origin.

Q What is central pain, please?

A Central pain means arising in the central nervous system, arising in the cortex of the central nervous system.

Q What does that mean in layman's terms?

A Layman's terms, would be – it would be pain coming from someone's head, not pain coming from a particular organ.

Q Is that a common phenomena?

A It's not unheard of in people that have this kind of problem.

No. 95-1858 (36)

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

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On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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TABLE OF CONTENTS

	Page
INTRODUCTION AND INTEREST OF *AMICI*	1
HEALTH CARE BACKGROUND	3
A. Commitment To Patient Autonomy	3
B. Physician-Assisted Suicide	4
C. Requests for Physician-Assisted Suicide	5
D. The Inherent Difficulty In Regulating Physician-Assisted Suicide	10
SUMMARY OF ARGUMENT	17
ARGUMENT	18
THE EQUAL PROTECTION CLAUSE DOES NOT PROHIBIT A STATE FROM DISTINGUISHING BETWEEN WITHHOLDING OR WITHDRAWING TREATMENT AND ASSISTING A SUICIDE	18
A. States Have A Rational Basis For Distinguishing Between Physician-Assisted Suicide And Withholding Or Withdrawing Medical Treatment	19
B. This Case Is Not Appropriate For A Legislative Remand	25
CONCLUSION	30

TABLE OF AUTHORITIES

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	Page
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	Page
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INTRODUCTION AND INTEREST OF *AMICI*

The right to control one's medical treatment is among the most important rights that the law affords each person. The associations of health care professionals who are submitting this brief strongly support the recognition and enforcement of that right. Health care professionals are committed to their ethical and legal obligations to honor patient requests to withhold or withdraw unwanted life-prolonging treatment and to provide patients with all medication necessary to alleviate physical pain, even in circumstances where such medication might hasten death.

Through these means, patients can avoid entrapment in a prolonged, painful, or overly medicalized dying process.

The decision below, however, takes the unprecedented step of invalidating a law that prohibits patients from obtaining the assistance of a physician in killing themselves. The court of appeals would confer upon health care professionals the awesome responsibility of deciding who, among the many patients who would request physician-assisted suicide, are eligible to receive it. The power to assist in intentionally taking the life of a patient is antithetical to the central mission of healing that guides both medicine and nursing. It is a power that most physicians and nurses do not want and could not control. Once established, the right to physician-assisted suicide would create profound danger for many ill persons with undiagnosed depression and inadequately treated pain, for whom physician-assisted suicide rather than good palliative care could become the norm. At greatest risk would be those with the least access to palliative care—the poor, the elderly, and members of minority groups.

The American Medical Association ("AMA"), the American Nurses Association ("ANA"), the American Psychiatric Association ("APA"), and 43 other national specialty and state medical societies that are submitting this brief [1] represent hundreds of thousands of health care professionals who care each day for millions of Americans. Our members have deep compassion for those who are suffering the pain and torment of chronic or terminal illness. We have learned much in recent years about palliative care. Our experience is that a desire for physician-assisted suicide does not persist in patients who receive good palliative care.

Amici acknowledge that many patients today do not receive proper treatment for their pain, depression, and

[1] Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Court. A brief description of each *amicus* appears as Appendix A to this brief.

psychological distress. Nevertheless, physician-assisted suicide is not the right answer to the problem of inadequate care. Although for some patients it might appear compassionate intentionally to cause death, institutionalizing physician-assisted suicide as a medical treatment would put many more patients at serious risk for unwanted and unnecessary death. Rather than recognize a right to physician-assisted suicide, our society should recognize instead the urgent necessity of extending to all patients the palliative care they need and redouble our efforts to provide such care to all.

HEALTH CARE BACKGROUND

To explain more fully the bases for *amici*'s position, we begin with a discussion of important aspects of caring for seriously ill patients who request physician-assisted suicide that were misapprehended by the court below.

A. Commitment To Patient Autonomy

The health care professions' ethical commitment to the principle of patient autonomy plays a vital role in providing patients with the ability to control their course of treatment. This commitment is expressed, for example, in Opinion 2.20 of the AMA Code of Medical Ethics. Opinion 2.20 provides, in part, that "[t]he principle of patient autonomy requires that physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decisionmaking capacity." AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* § 2.20 (App. 11a-12a); see also ANA, *Code for Nurses with Interpretive Statements* § 1.1 (App. 19a) (patients "have the moral right to determine what will be done with their own person" and "to accept, refuse, or terminate treatment without coercion").

Opinion 2.20 has great significance for patients near the end of life. To those who fear unwanted medical intervention in the dying process, the message of Opinion 2.20 is that a patient need not accept, and physicians

must not impose, a medical treatment that the patient does not want. As a practical matter, this means that a patient can refuse not only mechanical interventions such as respirators, feeding tubes, or dialysis, but also chemotherapy, antibiotics, or any other treatment that would have the effect of prolonging the patient's life. App. 12a. Through such means, persons suffering from chronic diseases (such as multiple sclerosis or amyotrophic lateral sclerosis), as well as terminal diseases, can plan with their physicians which life-sustaining treatment to accept.

Opinion 2.20 unequivocally establishes that "[p]hysicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care" and, significantly, that this obligation "includes providing palliative treatment even though it may foreseeably hasten death." App. 13a; see also App. 19a-20a (ANA Position Statement on Promotion of Comfort and Relief of Pain in Dying Patients). The recognition that physicians should provide patients pain medication sufficient to ease their pain, even where that may serve to hasten death, is vital to ensuring that no patient suffer from physical pain.

The principle of patient autonomy, however, has never been understood to give patients the right to every procedure or treatment they might demand. For example, physicians need not provide futile treatment—that is, treatment that has no reasonable chance of helping the patient. *Code of Medical Ethics* § 2.035 (App. 15a). Similarly, physicians should not provide patients with treatments that are known to be ineffective or harmful. Such limitations are important. If a patient may demand and receive anything from a health care professional, individuals who practice the healing arts will cease being professionals.

B. Physician-Assisted Suicide

Long viewed as outside the realm of legitimate health care, physician-assisted suicide occurs "when a physician facilitates a patient's death by providing the necessary

means and/or information to enable the patient to perform the life-ending act." *Code of Medical Ethics* § 2.211 (App. 11a); AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide*, 10 Issues in L. & Med. 91, 92 (1994). The practice involves physicians intentionally providing patients with the means for suicide, such as prescribing barbiturates in an amount certain to cause death and for the purpose of causing death. See, *e.g.*, Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691 (1991).

The ethical prohibition against physician-assisted suicide is a cornerstone of medical ethics. Its roots are as ancient as the Hippocratic Oath that a physician "will neither give a deadly drug to anybody if asked for it, nor . . . make a suggestion to this effect," and the merits of the ban have been debated repeatedly in this nation since the late nineteenth century. Most recently, the AMA has reexamined and reaffirmed the ethical prohibition against physician-assisted suicide in 1977, 1988, 1991, 1993, and 1996.[2] Physician-assisted suicide remains "fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks." *Code of Medical Ethics* § 2.211 (App. 11a). Other health care professions have similar tenets. See, *e.g.*, App. 19a (ANA Position Statement on Assisted Suicide). Physicians and nurses have the ability to respond sensitively to the concerns of seriously ill and dying patients and can meet their patients' needs without acceding to requests for suicide.

C. Requests for Physician-Assisted Suicide

1. Implicit in the Second Circuit's Opinion is the view that many of those who request suicide do so to avoid ex-

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[2] AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 477 (1996). Most recently, in the aftermath of the decision below, the AMA's House of Delegates in June 1996 overwhelmingly endorsed a recommendation to affirm the ban on physician-assisted suicide.

cruciating pain, and that health care professionals can do nothing compassionate in response other than to offer death. There is no evidence, however, that increasing numbers of patients are dying in severe pain. To the contrary, "[t]he potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts." AMA Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996). The pain of most terminally ill patients can be controlled throughout the dying process, without heavy sedation or anesthesia. *Id.*; see, *e.g.*, Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Pall. Care 25, 26 (1993); Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symp. Mgmt. 289 (1991); Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124 (1996). For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or weeks of life to prevent the patient from experiencing severe pain. N.Y. State Task Force, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 40 & n.21 (1994). Notably, when pain medication is properly administered, for most patients the risk of respiratory depression that hastens death is minimal. N.Y. State Task Force at 162.

Given the increasing ability to control pain, it is not surprising that the demand for physician-assisted suicide does not come principally from those seeking relief from physical pain. A recent study of such requests in Washington State found that "neither severe pain nor dyspnea was a common patient concern, suggesting that intolerable physical symptoms are not the reason most patients request physician-assisted suicide or euthanasia." Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996). This finding is consistent with a report from Compassion-in-Dying, see Preston & Mero, *Observations Concerning Terminally Ill Patients*

Who Choose Suicide, 4 J. Pharm. Care & Pain Symp. Control 183, 187 (1996) ("[i]n no patient was pain the primary reason for suicide"); with other studies of patients and physicians, see Emanuel *et al.*, *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 Lancet 1805, 1809 & nn.6, 12 (1996) ("[p]atients experiencing pain were not inclined to euthanasia or physician-assisted suicide"); as well as with studies of Holland's experience, see Van der Maas *et al.*, *Euthanasia and Other Medical Decisions Concerning the End of Life*, 338 Lancet 669, 672 (1991) (relief from pain was mentioned as a factor in fewer than half of cases, and was the sole factor in only five percent of cases).

This is not to say that all patients have access to and actually receive adequate pain relief and good palliative care. They do not. The delivery of such care is "grossly inadequate" today, and efforts to make such care universally available have not yet succeeded. N.Y. State Task Force at 43-47; Connors *et al.*, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). There are many obstacles to the delivery of adequate pain management. These include a lack of professional training and knowledge, misconceptions about the risk of addiction and respiratory depression associated with pain medication, inadequate communication (reflecting both inadequate attention from health care professionals and undue reluctance of patients and their families to use pain relief medication), and concern over criminal or licensure actions against the prescribing physicians. N.Y. State Task Force at 44-47; AMA Council, 275 JAMA at 476. Of further concern, individuals treated at centers that served predominantly minority patients are more likely than others to receive inadequate pain treatment; the same is true for elderly and female patients. N.Y. State Task Force at 44 & n.37. Yet for "many patients, pain and suffering could be alleviated using medications and techniques that have been widely publicized and require only modest resources." *Id.* at 35. There is,

in short, compelling evidence of the need to ensure that all patients have access to quality palliative care, but not of any need for physician-assisted suicide to control pain.

2. Most patients that request suicide do so out of concerns that, in the future, their pain may become intolerable, they may suffer a loss of dignity and become dependent upon others, or they will excessively burden their families. Back *et al.*, 275 JAMA at 921; Emanuel *et al.*, 347 Lancet at 1807. The suffering that such concerns may cause is real. But if the anticipatory and existential nature of that suffering is recognized and addressed, it can often effectively be alleviated. Foley, 6 J. Pain & Symp. Mgmt. at 289-90; N.Y. State Task Force at x, 181.

Concerns about the future loss of control, loss of dignity, or pain frequently can be met by reassuring the patient of a continuing commitment to attentive comfort care and by assisting the patient to confront an underlying and unspoken fear of death. "Many patients and physicians displace anxieties about death onto the circumstances of dying: pain, dependence, loss of dignity, and the unpleasant side effects of medical treatments. Focusing on or becoming enraged at the process distracts from the fear of death itself." Hendin, *Suicide, Assisted Suicide, and Euthanasia: Lessons from the Dutch Experience*, Summary of Testimony Presented to House Subcommittee on the Constitution 1 (1996). A full approach to palliative care addresses spiritual and existential feelings as well as personal and social burdens, using a team approach that draws on social workers and pastors as well as physicians and nurses. Clinicians with experience assisting dying patients to confront such concerns report that the desire for death passes, and that patients say they have found unexpected meaning in their lives that makes their final days worth living. *E.g.*, Cundiff, *Euthanasia Is Not the Answer* 29-39 (1992).

The anxieties that can accompany serious illness are often complicated, however, by the onset of depression.

Depression is the single factor found to be a significant predictor of the desire for death. Emanuel *et al.*, 347 Lancet at 1809; Chochinov *et al., Desire for Death in the Terminally Ill*, 152 Am. J. Psych. 1185, 1190 (1995). In one study of 44 terminally ill patients, all but one of the eleven patients with "clinical depressive illness" expressed some wish for death, while none of the remaining 33 expressed such a wish. Brown *et al., Is it Normal for Terminally Ill Patients to Desire Death?*, 143 Am. J. Psych. 208, 210 (1986); see also Conwell & Caine, *Rational Suicide and the Right to Die: Reality and Myth*, 325 New Eng. J. Med. 1100, 1101 (1991) ("of 44 patients in the later stages of cancer, only 3 had considered suicide, and each of them had a severe clinical depression"); AMA Council, 275 JAMA at 475; Chochinov *et al.*, 152 Am. J. Psych. 1185. In this regard, those with terminal or chronic illness are no different than others who express suicidal wishes. Most who commit suicide suffer from depression or some other diagnosable psychiatric illness, which generally is treatable. Hendin, *Suicide and the Request for Suicide: Meaning and Motivation*, 35 Duq. L. Rev. 285, 285 (1996); N.Y. State Task Force at 13, 180.

It is clear that "a substantial proportion of terminally ill patients who express a desire to die could potentially benefit from a trial of treatment for depression." Chochinov *et al.*, 152 Am. J. Psych. at 1190. For example, "[t]he elderly appear to be more prone than younger victims to take their lives during the type of acute depressive episode that responds most effectively to available, modern treatments." Conwell & Caine, 325 New Eng. J. Med. at 1101. Nevertheless, most physicians fail to recognize depression, thereby precluding the opportunity for effective treatment. *Id.* at 1101-02.

3. The demand for physician-assisted suicide among the terminally ill is thus best understood not as a necessary response to untreatable pain uniquely felt by the dying, but in the broader context of requests for suicide generally.

"Among all suicides, only two percent to four percent are terminally ill." N.Y. State Task Force at 12. Moreover, while severe chronic or terminal illness is a risk factor for suicide, "only a small percentage of terminally ill or severely ill patients attempt or commit suicide." *Id.* at 9, 13. And those patients are similar to physically healthy individuals who contemplate suicide—they "are usually suffering from a treatable mental illness, most commonly depression." *Id.*

Thus, contrary to the Second Circuit's most basic premise, terminal illness does not present a special case for physician-assisted suicide. Patients with chronic or terminal illness who seek physician-assisted suicide are typically depressed or anticipating extreme suffering. Their needs and concerns are ones that health care professionals can meet with compassionate care. There may be, even in a system that provides optimal palliative care to all patients, individuals whose pain may not be treatable absent sedation and whose wish for physician-assisted suicide to avoid sedation is sincere. But the number of such individuals is likely to be very small, and the social cost of accommodating their preference for physician-assisted suicide over sedation and withdrawal of treatment is likely to be high. For reasons that follow, even if physician-assisted suicide were thought appropriate for such patients, no one can predict with any confidence that physician-assisted suicide, if authorized by the state, could reliably be limited to them.

D. The Inherent Difficulty In Regulating Physician-Assisted Suicide

Proponents of physician-assisted suicide agree that lines must be drawn between categories of individuals for whom physician-assisted suicide is to be deemed acceptable or unacceptable. The Second Circuit purported to restrict physician-assisted suicide narrowly to those who were "in the final stages of terminal illness." Pet. App. 4a. In *Washington* v. *Glucksberg*, No. 96-110, the Ninth Circuit permitted physician-assisted suicide for all of those

with a "terminal illness." Pet. App., No. 96-110, at A-113 to A-114. Both courts expressly limited their holdings to the provision of physician-assisted suicide (Pet. App. 32a-34a & n.3; Pet. App., No. 96-110, at A-104), but the Ninth Circuit candidly expressed its doubt that any reasonable distinction could be maintained between physician-assisted suicide and voluntary euthanasia. The "critical line," the Ninth Circuit stated, was between the "voluntary and involuntary termination of an individual's life." *Id.* at A-100.

The Second Circuit acknowledged concern about "abuses found in the Netherlands," but expressed confidence that New York would be able to "establish rules and procedures to assure that all choices are free of such pressures." Pet. App. 33a; see also *id.* at 34a n.4. There is no realistic basis for such confidence. Callahan & White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 U. Rich. L. Rev. 1, 83 (1996). Existing rules limiting physician-assisted suicide are not being followed today. AMA Bd. of Trustees, *Euthanasia/Physician-Assisted Suicide: Lessons in the Dutch Experience*, 10 Issues in L. & Med. 81 (1994). For example, the study of euthanasia and physician-assisted suicide commissioned by the Dutch government showed that approximately one in four cases of euthanasia did not qualify as voluntary under the guidelines. Van der Maas *et al.*, 338 Lancet at 671; Kass & Lund, *Physician-Assisted Suicide, Medical Ethics and the Future of the Medical Profession*, 35 Duq. L. Rev. 395, 412-13 & nn.29-30 (1996). Different social circumstances in the United States make effective regulation even less likely here than in Holland. See AMA Bd. of Trustees, 10 Issues in L. & Med. at 88-89. Difficulties inherent in the regulation of physician-assisted suicide suggest that even strenuous efforts to regulate such a practice will not succeed.

1. The Second Circuit placed principal reliance on its assumption that physician-assisted suicide could be re-

stricted to those in the last stages of a terminal illness. An initial difficulty arises, however, even in identifying the eligible class. Available evidence suggests "that physicians' predictions of expected remaining life are generally inaccurate." Callahan & White, 30 U. Rich. L. Rev. at 46 n.202. For example, while admission to hospice is contingent on a diagnosis of six or fewer months to live, a recent study showed that 15 percent of hospice patients survived longer than six months and eight percent survived longer than one year. Christakis & Escarce, *Survival of Medicare Patients after Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172 (1996); see Lynn *et al., Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duq. L. Rev. 311 (1996). Life expectancy is thus inherently problematic as a criterion for establishing eligibility to exercise a constitutional right.

The lack of clear-cut lines between those who are terminally ill and those who are in the last stages of a terminal illness suggests that any attempt to limit the availability of physician-assisted suicide to the latter would be arbitrary. But the same is true for the line between the terminally ill and the chronically ill. No one can confidently say that the degree of pain or suffering experienced by a person in the last stages of a terminal disease is greater than that experienced by someone at an earlier stage of terminal illness, or by someone who is chronically ill. Moreover, if the pain or suffering is thought to be irremediable, then the longer the patient's life expectancy, logically the more pain and suffering awaits the patient. Kamisar, *Against Assisted Suicide—Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735, 737, 740-41 (1995). There would thus be little to prevent expansion of physician-assisted suicide beyond the confines of the last stages of terminal illness.

The experience in the Netherlands illustrates the difficulty of hewing to particular guidelines. Physician-assisted suicide and euthanasia remain unlawful but are not prose-

cuted if performed by a physician in accordance with established procedures. Keown, "Some Reflections on Euthanasia in the Netherlands," *in Euthanasia, Clinical Practice and the Law* 193, 197 (Gormally ed., 1994). In one recent, much-discussed case, a physician, who assisted in the suicide of a physically healthy, 50-year-old woman who sought death in the aftermath of the death of her two sons, was acquitted by a three-judge court in Assen of charges that he had violated the Dutch procedures. The Assen case is significant in that it "marked Dutch acceptance of depressed suicidal patients as eligible for assisted suicide or euthanasia," Hendin, *Seduced by Death: Doctors, Patients, and the Dutch Cure*, 10 Issues in L. & Med. 123, 129 (1994), and thereby demonstrated the difficulty of restricting the availability of physician-assisted suicide even to those with a physical illness.

2. There are also formidable obstacles to restricting physician-assisted suicide only to those patients who voluntarily request it. First, the fact that many patients do not receive adequate pain relief or suffer from undiagnosed and untreated depression puts undue pressure on them to seek physician-assisted suicide. A substantial percentage of elderly patients suffer mental confusion that also routinely goes undiagnosed. Francis *et al., A Prospective Study of Delirium in Hospitalized Elderly*, 263 JAMA 1097 (1990). Moreover, poor and minority individuals are at the greatest risk for receiving inadequate care and thus may feel the greatest pressure to request physician-assisted suicide.

Pressure to contain health care costs exacerbates the problem. Even if, as one would expect, health care insurers would consciously seek to avoid suggesting to patients or physicians that they consider financial costs in making a decision to hasten death, the continuing pressure to reduce costs can only constrain the availability and quality of palliative care and support services that patients and families need. Wolf, *Physician-Assisted Suicide in the Context of Managed Care*, 35 Duq. L. Rev. 455 (1996).

These limitations on the availability of proper care clearly can place pressure on patients to express a wish for suicide that they might not otherwise feel. As the Chief of the Pain Service at Memorial Sloan-Kettering Cancer Center reports, "[w]e commonly see [requests for physician assisted suicide] dissolve with adequate control of pain and other symptoms." Foley, 6 J. Pain & Symp. Mgmt. at 290.

Providers willing to comply with requests for suicide may be among those least sensitive to the impact of these pressures and least familiar with alternative responses to their patients' needs. A recent study shows that support for physician-assisted suicide was highest among those health care professionals least knowledgeable about pain symptom management and least capable (due to emotional exhaustion) of empathizing with the patient. Portenoy *et al., Determinants of the Willingness to Endorse Assisted Suicide: A Survey of Physicians, Nurses, and Social Workers,* ——Psychosomatics —— (forthcoming April 1997); see also Bachman *et al., Attitudes of Michigan Physicians and the Public toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia,* 334 New Eng. J. Med. 303, 308 (1996) ("doctors who had the least contact with terminally ill patients were the most likely to support the legalization of assisted suicide"). There is thus added reason to doubt that patients seeking physician-assisted suicide would receive adequate palliative care before such a request is granted.

Second, separating the wishes of the patient from those of the family is extremely problematic. One of the most common reasons why patients request suicide is to spare their families and loved ones the burdens and expense of caring for them. See, *e.g.*, Blendon *et al., Should Physicians Aid Their Patients in Dying?,* 267 JAMA 2658, 2660-61 (1992); Emanuel, *Cost Savings at the End of Life: What Do the Data Show?,* 275 JAMA 1907 (1996). But to what extent are these feelings the result of the family's expectations? In one recent study, families of

elderly, terminally ill patients were significantly more likely than the patients themselves to express support for physician-assisted suicide. Koenig *et al., Attitudes of Elderly Patients and Their Families toward Physician-Assisted Suicide,* 156 Arch. Int. Med. 2240, 2244 (1996). Families, especially when confronted with the expense and burden of caring for a terminally ill family member, may be beset with conflicting feelings about hastening a family member's death, as recent cases vividly illustrate. *E.g.*, "Countdown to a Suicide," *The New York Times,* Dec. 20, 1995, at A-20 (Delury case). Even those family members consciously committed to preserving their loved one's sense of dignity and autonomy may needlessly acquiesce in or encourage a suicide that could be avoided by assuring the patient that, in their eyes, illness has not compromised his or her dignity. Byock, "Physician-Assisted Suicide Is *Not* an Acceptable Practice for Physicians," *in Physician-Assisted Suicide: Ethical Positions, Medical Practices, and Public Policy Options* —— (Weir ed., forthcoming May 1997).

Third, experience to date provides little basis for confidence that health care professionals can reliably determine whether patients have provided truly informed consent for assisted suicide. Frank, sensitive, and extended conversations between physicians and patients are presumptively antecedents to such a determination. Such conversations would be infinitely more complex than any that regularly occur today. For example, ineffective communication remains a major obstacle to achieving pain management, American Pain Society Quality of Care Committee, *Quality Improvement Guidelines for the Treatment of Acute Pain and Cancer Pain,* 274 JAMA 1874, 1874 (1995), even though pain relief is plainly a goal shared by both health care professionals and patients. And despite their importance, discussions about advance care planning are rare and poorly handled, therefore hampering effective and responsive end-of-life care. Emanuel, "Advance Directives," *in Principles and Practice of Supportive Oncology* —— (Berger *et al.* eds., forthcoming 1996).

The well-established phenomena of transference and countertransference further complicate the problem of relying upon physicians and nurses to identify voluntary requests. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786 (1994). Particularly when caring for chronically ill, dying, or suicidal patients, caregivers often have "difficulty tolerating such patients' dependency." *Id.* at 1786 (footnote omitted). Their "feelings of frustration and inadequacy occasioned by irreversible medical problems" sometimes lead them "to withdraw from such patients or see them as hopelessly or rationally suicidal" when in fact they are not, which "in turn may precipitate suicides." *Id.* As one physician with extensive experience caring for dying patients has observed "[o]nly because I knew that I could not and would not kill my patients was I able to enter most fully and intimately into caring for them as they lay dying." Miles, *quoted in* Kass & Lund, 35 Duq. L. Rev. at 418.

Health care professionals also experience great frustration at not being able to offer the patient a cure. For some, the ability to offer the patient the "treatment" of assisted suicide may provide a sense of "mastery over the disease and the accompanying feelings of helplessness." Hendin, *Seduced by Death*, 10 Issues in L. & Med. at 129. This may cause health care professionals or a patient's family to endorse and reinforce requests for suicide more readily than the patient's own ambivalent feelings would warrant. Miles, 271 JAMA at 1786. Published accounts of physician-assisted suicide reveal that even those physicians who consciously seek only to implement a patient's voluntary request overlook ways in which their recommendation and support of physician-assisted suicide reinforced the patient's decision for death and left unexamined indications that the patient really did not want to die. Hendin, *Selling Death and Dignity*, 25 Hast. Ctr. Rep. 19 (1995); Hendin, *Seduced By Death*, 10 Issues in L. & Med. at 125-29.

3. The obstacles to identifying and restricting physician-assisted suicide to those patients who meet criteria of terminality and voluntariness are not likely to be overcome simply by devoting more resources to oversight of treatment decisions. Indeed, the unprecedented intrusion into the physician-patient relationship needed independently to regulate such treatment decisions would be fundamentally inconsistent with the private nature of health care treatment, and all too likely to undermine what progress has been made in decisions to withdraw or withhold life-sustaining treatment and to use effective pain control. Callahan & White, 30 U. Rich. L. Rev. at 67, 80.

Transforming physician-assisted suicide into a medical procedure would create momentum in favor of its use that regulation could not reverse. Were physician-assisted suicide to become a legitimate medical option, then a decision not to select that option would make many patients feel responsible for their own suffering and for the burden they impose on others. Once a patient can choose physician-assisted suicide, it is but a short step to ask a patient why he or she has not done so. Indeed, it seems likely the patient would feel pressure to revisit the question repeatedly, perhaps every day. Many patients thus will "experience—and be helped [by their families or physicians] to experience—their right to choose physician-assisted death as a *duty* to do so." Kass & Lund, 35 Duq. L. Rev. at 407.

SUMMARY OF ARGUMENT

The Second Circuit refused to find that patients have a liberty interest in choosing the time and manner of their death. Pet. App. 16a-20a. It nevertheless invalidated New York's prohibition on assisted suicide to the extent the law prohibits "a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness." *Id.* at 35a. The court concluded that the law, applied in this fashion, was "not rationally related to any legitimate state interest." *Id.* The court therefore found that

New York State's ban on assisted suicide violates the Equal Protection guarantee of the Fourteenth Amendment.

In so ruling, the court strained to conclude that it was irrational for a state to distinguish between laws permitting patients to have unwanted medical treatment withheld or withdrawn and laws prohibiting physicians from assisting their patients to commit suicide. In the court's view, both procedures involved the physician in assisting a suicide. The court's attempt to equate the two procedures ignores not only the venerable common law and ethical distinction between the two procedures, but the vital concerns for patient welfare that justify the line drawn by the state.

Although reaching a holding superficially more narrow than that of the Ninth Circuit's ruling (the Second Circuit's holding is restricted to those "in the last stages" of a terminal illness), the Second Circuit's decision is, as a practical matter, every bit as broad as the Ninth Circuit's in its implications and practical import. The Second Circuit never asked whether the new line that it drew is any more rational than the one it had just erased. The answer, quite simply, is that it is not. The restrictions that the Second Circuit assumed could be imposed on physician-assisted suicide are, in fact, less rational than the state's outright prohibition, and could not be expected to survive comparable constitutional scrutiny.

ARGUMENT

THE EQUAL PROTECTION CLAUSE DOES NOT PROHIBIT A STATE FROM DISTINGUISHING BETWEEN WITHHOLDING OR WITHDRAWING TREATMENT AND ASSISTING A SUICIDE.

The Second Circuit did not find, and no one could reasonably argue, that states do not have a rational basis for prohibiting physician-assisted suicide. The court instead found that it was irrational for New York to prohibit physician-assisted suicide for patients in the last stages of terminal illness while at the same time permitting patients to request that physicians withdraw or withhold life-

sustaining treatment. Because the latter involves a physician taking action that hastens a patient's death, the court reasoned that it amounted to physician-assisted suicide. Such precedent made it irrational, in the court's view, for the state to maintain a ban against physician-assisted suicide for patients in the last stages of terminal illness.

The principal question before this Court, therefore, is whether it is rational for a state to distinguish between patients' requests for physician-assisted suicide and requests for withholding or withdrawing life-prolonging treatment. There are, in fact, many sound reasons for drawing the line New York has adopted that amply support the law as rationally justified. In addition to reversing the lower court's equal protection holding, the Court should also reject the argument, offered in the concurring opinion below, that New York's law should be invalidated and, in effect, remanded to the legislature for further consideration.

A. States Have A Rational Basis For Distinguishing Between Physician-Assisted Suicide And Withholding Or Withdrawing Medical Treatment

The distinction between the right to refuse unwanted medical treatment and physician-assisted suicide reflects a venerable common law tradition, acknowledged and described at length by the Court in *Cruzan* v. *Director, Missouri Department of Health*, 497 U.S. 261, 269-79 (1990), that distinguishes between respecting a patient's right to refuse unwanted medical treatment on one hand and respecting the state's interest in preventing suicide on the other. Medical treatment performed without the patient's consent historically has been treated as a battery, excusable only in emergency circumstances. *Id.* at 270; Keeton *et al.*, *Prosser and Keeton on the Law of Torts* 39-42, 190 (5th ed. 1984); *Winters* v. *Miller*, 446 F.2d 65, 68 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971). The right to refuse treatment is the "logical corollary" of the prohibition against medical treatment without the patient's informed consent. *Cruzan*, 497 U.S. at 270.

Physician-assisted suicide, in contrast, does not involve the imposition of treatment against the patient's will. It does not rest on the same common law antecedents as the right to refuse treatment. Indeed, any assistance in helping another commit suicide has long been prohibited at common law—a fact that this Court expressly observed in *Cruzan* without suggesting that it was inconsistent with the historic tradition of protecting a right to refuse medical treatment. *Id.* at 280. The traditions of the common law alone provide the state with a rational basis for the distinction it makes.

Second, the common law traditions reflect an important moral and practical difference that the Second Circuit failed to appreciate. The Second Circuit was able to equate withdrawal of medical treatment with physician-assisted suicide only by misconceiving the fundamental difference in the physician's intent in participating in those two acts. In respecting a patient's decision to have treatment withheld or withdrawn, the physician is acting squarely within the historic parameters of the profession. The physician is fulfilling his or her role as someone who responds to the patient's needs by providing medical treatment only to the extent the patient consents. Although the act of withholding or withdrawing medical treatment may lead to death, the intent of the physician in so acting is not to cause death, but to respect the patient's essential right to decide if and when to let the disease process take its course.

Conversely, when the physician responds affirmatively to a request for help in committing suicide, the physician's intent is only to help the patient in taking his or her life. The physician thus acts with intent to kill. To distinguish between two acts with a similar result based upon the intent of the actor is elemental in the law. *Morissette* v. *United States*, 342 U.S. 246, 250 (1952) (legal distinctions based on intent are "universal and persistent in mature systems of law"). There can be little doubt that

a state acts rationally when it chooses to respect such a distinction in this context.

Third, states could rationally conclude that preserving the ethical boundary as drawn by the medical and nursing professions is important to prevent serious damage to those professions and their ability to serve patients. *E.g., Semler* v. *Oregon State Bd. of Dental Examiners*, 294 U.S. 608, 612-13 (1935) (state's strong interest in "maintenance of professional standards" permits it to enforce "a general rule even though in particular instances there might be no actual" harm); *Ohralik* v. *Ohio State Bar Ass'n*, 436 U.S. 447, 460 (1978) (state interest in "maintaining standards among members of the licensed professions" is "particularly strong"); *Shapero* v. *Kentucky Bar Ass'n*, 486 U.S. 466, 485 (1988) (state "should have considerable latitude to ban" conduct that "undermines the substantial government interest in promoting the high ethical standards" of a profession) (O'Connor, J., dissenting).

Health care professionals have long understood that with the right to practice comes enormous responsibility. Patients come to physicians and nurses at times of greatest need and vulnerability, depending upon these professionals to respond to their needs capably and faithfully. The rule against physician-assisted suicide is an extraordinarily valuable protection against temptation to seek an immediate solution to a burdensome problem that health care professionals, no less than any other human being, can feel. Many patients may understandably wonder, finding themselves badly injured and in the care of a physician they do not know but who is licensed to assist in taking the lives of patients, whether that physician will truly act only to preserve their lives. Will patients be confident, as they watch a physician draw a dose of morphine, that the physician is committed only to easing their pain and not to taking their lives? See, *e.g.*, Kass & Lund, 35 Duq. L. Rev. at 408. The ban on physician-assisted suicide helps ensure that patients will never lose the trust that must exist for the physician-patient relationship to flourish.

Fourth, states could reasonably conclude that abandoning the prohibition on physician-assisted suicide will undermine the provision of palliative care to those who need it. Such a step may discourage some patients from seeking adequate pain medication for fear that a request for such medication will initiate a process that could lead to physician-assisted death. States could also conclude that abandoning the prohibition would undermine the professions' overall efforts to expand the provision of palliative care to all patients. Although such efforts would not end if physician-assisted suicide were permitted, the prohibition on physician-assisted suicide provides health care professionals with a tremendous incentive to improve and expand the availability of palliative care.

Similarly, states also could reasonably conclude that preserving the prohibition against physician-assisted suicide is essential to avoid jeopardizing the hard-won advances over the past decade firmly to establish for all patients a right not only to have unwanted medical treatment withheld or withdrawn but also to receive pain medication sufficient to ease pain, even if that medication might hasten the patient's death. Widespread acceptance of these rights by health care professionals, courts, legislatures, and the public has been dependent upon the recognition and acceptance of the distinction between these rights and physician-assisted suicide. See generally 2 Meisel, *The Right To Die* § 18.18, at 479-85 (2d ed. 1995). If that important boundary is lost, much support for withholding and withdrawing treatment or providing adequate pain medication may be lost as well.

Fifth, states could reasonably conclude that the potential for abuse is significantly greater in the context of physician-assisted suicide than in the case of the withholding or withdrawal of treatment. It is true that the difficulty of identifying truly voluntary requests for physician-assisted suicide has some analogue in the context of requests to withhold or withdraw medical treatment. But the analogy is only partial at best. The right to refuse treatment is a

right that applies to all competent, informed individuals at any time. The right articulated by the court below to physician-assisted suicide is one that purports to be limited to very discrete categories of patients. Such a right requires physicians to make multiple subjective judgments that simply are not required in the typical withholding or withdrawal situation. Moreover, the historic protection for a patient's right to limit what others may do to the patient's body supports a degree of deference to patient decisions to withdraw and withhold treatment that is absent in the case of physician-assisted suicide.

Sixth, honoring the patient's right to refuse unwanted care serves a vital, life-promoting purpose that has no equally strong analogue in permitting physician-assisted suicide. There would be a strong disincentive to accepting life-sustaining treatment if patients and their surrogates knew that, once the treatment were started, it could never be stopped. For example, it may not be until some months after treatment begins before it can be known whether a patient in a vegetative state as a result of an accident will recover consciousness. And even apart from emergency situations, "the decision to initiate treatment is often acceptable to the patient and to the health care professionals because treatment can be withdrawn or withheld if the patient's condition worsens or the treatment proves intolerable for the patient." N.Y. State Task Force at 147.

Finally, a state could reasonably conclude that, given the difficulty of persuasively defending and enforcing rules that allow some categories of patients, but not others, to obtain physician-assisted suicide, and given the state's unquestioned interest in preventing avoidable suicides, an outright prohibition is best. The artificiality of the line drawn by the panel below is instructive. For example, the panel limited its holding to those who could "self-administer" the lethal drug, in effect distinguishing between physician-assisted suicide and voluntary euthanasia. Pet. App. 35a. But the court never explained how enforcement of that distinction would survive the court's scrutiny. As the

Ninth Circuit candidly admitted, "it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician." Pet. App., No. 96-110, at A-100. Unlike the Second Circuit, the Ninth Circuit "recognize[d] that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them." *Id.* (footnote omitted).

The panel would also limit physician-assisted suicide to those in the "last stages" of a terminal illness. Pet. App. 35a. The rationality of this limit, too, is undefended. As discussed above, physicians are not capable of accurately predicting the amount of time each patient has left to live. More fundamentally, the Second Circuit offered no rationale whatsoever, let alone one that could withstand the degree of scrutiny it applied below, for denying physician-assisted suicide to a terminally ill person in great pain and suffering while simultaneously granting it to a person in the last stages of a terminal illness. Certainly the logic that the Second Circuit used to invalidate the state's rule—that in allowing withdrawal of treatment the state has already approved physician-assisted suicide—would apply *a fortiorari* to claims by the terminally ill.

Indeed, the Second Circuit's logic would apply beyond the terminally ill to other patients as well. There is, based on the Second Circuit's reasoning, no rational basis for limiting physician-assisted suicide to those, for example, who are chronically ill but nevertheless experiencing great and irremediable pain or suffering. By hypothesis, such patients would be required to endure more pain and suffering than a person in the last stages of a terminal illness if the right to physician-assisted suicide were not extended to them. In such a case, a court might well encapsulate its ruling in words that track nearly verbatim those used below: "[W]hat business is it of the state to require the

continuation of agony when the result is imminent and inevitable?" *Cf.* Pet. App. 31a.

Furthermore, a state could rationally conclude that the imposition of a panoply of safeguards, such as those listed in a footnote below (see Pet. App. 34a-35a n.4), would not be effective in regulating physician-assisted suicide. Surely the experience in the Netherlands alone would provide a state with a rational basis for skepticism that such rules could be enforced. The essential confidentiality of the relationship between patients and their physicians and nurses precludes any effective monitoring of physician-assisted suicide, at least absent a kind of intrusive oversight that states could very rationally wish to avoid. *E.g.*, Callahan & White, 30 U. Rich. L. Rev. at 67.

For these reasons, the line drawn by the Second Circuit is no more immune to challenge on rationality grounds than the line the court struck down. Where the problems are as complex and sensitive as the ones at issue here, and where core state interests in protecting the health and welfare of its citizens are at stake, courts should be particularly reluctant to conclude that they can draw a more rational line than the one chosen by the vast majority of state legislatures and reflected in the common law.

B. This Case Is Not Appropriate For A Legislative Remand

This Court also should not adopt Judge Calabresi's view, expressed in the concurring opinion below, that New York's law should be invalidated and the legislature required, if it wishes to maintain its prohibition, to reenact the provision or some variation. Pet. App. 35a-62a. Judge Calabresi stated that "when a law is neither plainly unconstitutional . . . nor plainly constitutional, the courts ought not to decide the ultimate validity of that law without current and clearly expressed statements, by the people or by their elected officials, of the state interests involved." Pet. App. 51a. Judge Calabresi then concluded that "the rationale for the New York assisted-suicide prohibition

has eroded with the passage of time," that these laws have become obsolete, and in light of this obsolescence should be held unconstitutional. Pet. App. 55a-56a. He left open the possibility, however, that "such prohibitions, or other more finely drawn ones, might be valid, under either or both clauses of the United States Constitution, were New York to reenact them while articulating the reasons for the distinctions it makes . . . ." Pet. App. 62a.

Whatever the merits of this approach in other circumstances, the circumstances of this case counsel strongly against its application here. The premise of Judge Calabresi's argument—that New York's law against assisted suicide may simply be a vestige of another era, reflecting only legislative inattention or outdated state interests—is simply incorrect. New York has repeatedly revisited its laws on suicide, assisted suicide, and end-of-life care, and has kept its prohibition against assisted suicide intact. A brief history of this prohibition illustrates this point.

While assisted suicide has always been a crime in New York State, the legislature has revisited related laws many times. Until 1919, for example, attempted suicide was also a crime. At that time, criminal penalties were removed. and attempted suicide was declared to be a "grave public wrong." Act of May 5, 1919, ch. 414, §§ 1, 2, 1919 N.Y. Laws 1193; *Hundert* v. *Commercial Travelers' Mut. Accident Ass'n of Am.*, 279 N.Y.S. 555, 556 (N.Y. App. Div. 1935). Then, in 1965, the legislature deleted the "grave public wrong" language and redrafted the prohibition against assisted suicide to make it a separate substantive offense. Pet. App. 40a-41a.

Since 1965, a wide range of related issues have been considered by the New York legislature and courts, issues which have placed the question of assisted suicide squarely before the state's various governmental bodies. In 1981, the New York Court of Appeals held that physicians could lawfully honor patients' requests to terminate medical treatment. *In re Storar*, 420 N.E.2d 64 (N.Y.), *cert. denied*

sub nom. Storar v. *Storar*, 454 U.S. 858 (1981). In 1986, the New York Court of Appeals expanded this concept, holding that "it is the individual who must have the final say in respect to decisions regarding his medical treatment." *Rivers* v. *Katz*, 495 N.E.2d 337, 314 (N.Y. 1986).

Responding to *Katz*, the New York legislature enacted the 1987 Orders Not to Resuscitate Act, which provides competent adults with the right to create an order not to resuscitate. N.Y. Pub. Health Law §§ 2960-2979 (McKinney 1993 & Supp. 1996). In 1990, the legislature went further and permitted a competent person to designate an agent to make health care decisions, including the withdrawal of artificial nutrition and hydration. N.Y. Pub. Health Law § 2982 (McKinney 1993 & Supp. 1996). Through all this activity, the assisted suicide prohibition remained intact. Indeed, the 1990 Act further stated that "[t]his article is not intended to permit or promote suicide, assisted suicide, or euthanasia; accordingly, nothing herein shall be construed to permit an agent to consent to any act or omission to which the principal could not consent under law." N.Y. Pub. Health Law § 2989(3) (McKinney 1993 & Supp. 1996). Thus, as recently as 1990, the New York legislature (1) had before it the question of assisted suicide; (2) indicated that the resuscitation statutes are not intended to permit or promote assisted suicide; and (3) left in place its longstanding prohibition against such acts.

In 1994, the issue was again brought to the attention of the legislature when the New York State Task Force on Life and the Law ("Task Force") submitted its report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994), to the legislature. Although the members of the Task Force held "different views about the ethical acceptability of assisted suicide and euthanasia," they "unanimously recommend[ed] that existing law should not be changed to permit these practices." N.Y. State Task Force at xii. The Task Force con-

cluded that "[a]ssisted suicide and euthanasia would carry us into new terrain—American society has never sanctioned assisted suicide or mercy kiling," and that "the practices would be profoundly dangerous for large segments of the population." *Id.* at vii-viii. The New York State legislature received the report in 1994 and—possibly in reliance on the conclusions contained within it—has left the State's assisted-suicide statute intact.

More generally, there has been widespread national debate about the propriety of assisted suicide and euthanasia. Oregon, Washington, and California have all recently included assisted suicide referenda on their ballots. Pet. App., No. 96-110, at A-49. The Michigan courts and legislatures have given great consideration to this issue in response to the activities of Jack Kevorkian. See, *e.g.*, *People* v. *Kevorkian*, 527 N.W.2d 714 (Mich.) (holding that Michigan's ban on assisted suicide is constitutional), *cert. denied*, 115 S. Ct. 1795 (1994). As Professor Burt notes, "the current, dramatic public ferment regarding physician-assisted suicide . . . in itself shows that no judicial intervention is now necessary to give visibility and moral salience to the minority claims at stake." Burt, *Constitutionalizing Physician-Assisted Suiside: Will Lightning Strike Thrice?* 35 Duq. L. Rev. 159, 180 (1996).

The premise of Judge Calabresi's argument—that legislative inattention to New York's prohibition on assisted suicide requires courts to invalidate the law pending further legislative action—is thus not supported by the facts. There is ample evidence that New York's prohibition against assisted suicide reflects a contemporaneous legislative judgment that the prohibition remains important. The indicia of obsolescence must be far greater to justify the intrusive step of invalidating state law.

The decisions on which Judge Calabresi primarily relies do not support a legislative remand here. In *Abele* v. *Markle*, 342 F. Supp. 800 (D. Conn. 1972), *vacated*,

410 U.S. 951 (1973), Judge Newman, in a concurring opinion, found unconstitutional an 1860 prohibition on abortion because the state "interests which the 1860 legislature was seeking to advance are not today sufficient to justify" a continuing ban. *Id.* at 810. Here, however, the continuing vitality of the state's interests has been eloquently stated in a recent task force report commissioned by the state itself.

The other decisions cited below involved statutes that were ambiguous on the point at issue. Thus, in *Kent* v. *Dulles*, 357 U.S. 116, 129 (1958), the Court concluded that it should not be assumed, without more explicit direction, that Congress had delegated authority to the State Department to impose the challenged limitations on citizens' passport rights. And in her concurrence in *Thompson* v. *Oklahoma*, 487 U.S. 815 (1988), Justice O'Connor concluded that where state law "authorizes capital punishment for murder, without setting any minimum age at which the commission of murder may lead to the imposition of that penalty" and "quite separately [provides] that 15-year-old murder defendants may be treated as adults in some circumstances," there was a "considerable risk that the Oklahoma Legislature did not realize that its actions would have the effect of rendering" 15-year-olds eligible for the death penalty. *Id.* at 857. In view of that ambiguity, Justice O'Connor was prepared to require that Oklahoma clarify whether a juvenile could, in fact, be executed before such an execution would be permitted. *Id.*

No such ambiguity exists here. The New York law prohibiting assisted suicide is clear on its face.[8] And, as

[8] New York law provides that "A person is guilty of manslaughter in the second degree when . . . [h]e intentionally causes or aids another person to commit suicide" and "is guilty of promoting a suicide attempt when he intentionally causes or aids another person to attempt suicide." N.Y. Penal Law §§ 125.15, 120.30 (McKinney 1987).

the history of this provision makes clear, there is no reason to believe that the New York legislature "did not realize that its actions" (*id.*) had criminalized assisted suicide. In short, there is no basis for a legislative remand.

CONCLUSION

For the reasons stated above, the judgment of the court of appeals should be reversed.

Respectfully submitted,

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APPENDICES

APPENDIX A

AMICI CURIAE

The **American Medical Association (AMA)** is a private, voluntary, non-profit organization of physicians. The AMA was founded in 1847 to promote the science and art of medicine and to improve the public health. The 290,000 members of the AMA practice in all states and in all fields of medical specialization. Among other efforts, the AMA is working with the Robert Wood Johnson Foundation in the development of an education program on advance care planning and palliative medicine designed to reach every physician and to improve the quality of patient care for individuals at the end of life.

The **American Nurses Association (ANA)** is an association of registered nurses that is dedicated to the advancement of the goals and interests of registered nurses and of the nursing profession generally. It was founded in 1897 to promote the professional and educational advancement of nurses and to establish and maintain a code of ethics for the nursing profession. The ANA has 180,000 members and represents registered nurses in the United States and its territories through its 53 constituent member organizations. The ANA establishes professional standards for nursing practice, nursing education, nursing services and a code of ethical conduct for nurses, and the Association is dedicated to meeting the needs of nurses as well as the needs of patients and families.

The **American Association of Critical-Care Nurses (AACN)** is the world's largest specialty nursing organization with more than 76,000 members. Founded in 1969, the Association now has more than 270 chapters worldwide and is working toward a healthcare system driven by patient's needs where critical care professionals make their optimal contribution.

The **Hospice Nurses Association (HNA)** was founded in 1986 and is a non-profit professional association. The

HNA is an international professional association with a mission of promoting excellence in hospice nursing. The HNA is the nation's largest hospice nursing association and it is governed by an all nurse board of directors.

The **Oncology Nurses Society (ONS),** incorporated in 1975, is a national organization of more than 25,000 registered nurses specializing in cancer and dedicated to excellence in patient care, teaching, research and education in the field of oncology. The ONS has 185 local chapters that provide community networks for education and peer support. Oncology nurses are at the forefront of promoting quality of life as an essential component of cancer care.

The **American Osteopathic Association (AOA),** celebrating its centennial in 1997, represents the nation's 40,000 osteopathic (D.O.s). The AOA is organized to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality and cost-effective health care in a distinct, unified profession.

The **American Psychiatric Association (APA),** with approximately 42,000 members, is the nation's leading organization of physicians specializing in psychiatry. The APA follows the ethics standards of the American Medical Association. Physician-assisted suicide inevitably presents issues concerning the assessment of patient competence, the determination of voluntariness, and the diagnosis and treatment of depression or other mental illness afflicting patients who may request assistance for suicide. As doctors who would be called upon to play a critical role in such matters, the APA's members have a strong interest in this case.

The **American Academy of Hospice and Palliative Medicine (AAHPM),** originally organized as the Academy of Hospice Physicians in 1988, was established to bring together physicians interested and/or involved in the

hospice/palliative care approach to patient care and committed to improvement of care for the dying. The AAHPM is the only such organization in the United States that offers support to physicians dedicated to the advancement of hospice/palliative medicine, its practice, research and education. Its 1,500 member physicians represent nearly all medical specialties.

The **American Academy of Pain Management** was incorporated in 1988 as a voluntary, not-for-profit organization for the purpose of credentialing multidisciplinary pain practitioners, and to further the practice of pain management through the development of standards, education, and advocacy in the field of pain management. The Academy's Board of Advisors are prominent individuals in their respective disciplines and all are interested in furthering our knowledge and management of pain complaints. The intent of the Academy is to be inclusionary, not restrictive to any specialty, and the goal of the Academy is to bring together the many professionals who work with patients in pain and to assist in the creation of quality services for those individuals.

The **American Academy of Pain Medicine** is a medical specialty society of 900 physicians who specialize in the prevention, evaluation, diagnosis, treatment and rehabilitation of painful disorders. The pain physician serves as a consultant to other physicians but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitative services, performing pain relieving procedures, counseling of patients and families, direction of a multidisciplinary team, coordination of care with other health care providers and consultative services to public and private agencies pursuant to optimal health care delivery to the patient suffering from a painful disorder.

The **American Academy of Orthopaedic Surgeons** is a not-for-profit organization that represents over 17,000 mem-

bers. The Academy provides educational programs for orthopaedic surgeons, allied health professionals, and the public. The Academy is an advocate for improved patient care.

The **American Academy of Physical Medicine and Rehabilitation** is a national medical specialty society representing more than 5,000 physicians who specialize in physical medicine and rehabilitation (physiatry), the branch of medicine emphasizing the prevention, diagnosis and treatment of disorders that may produce temporary or permanent impairment. Physiatry provides integrated care in the treatment of all neurologic and musculoskeletal disabilities from traumatic brain injury to lower back pain. The specialty focuses on the restoration of function to people with problems ranging from simple physical mobility issues to those with complex cognitive involvement.

The **Society of Critical Care Medicine (SCCM)** is the premier professional international organization devoted exclusively to the advancement of multidisciplinary critical care through excellence in patient care, education, research and advocacy. The nearly 9,000 members of SCCM—the intensivists, nurses and allied health professionals involved in the care of the critically ill and injured —blend their knowledge, skill, and expertise into a coordinated effort to achieve the best possible outcome for the patient.

The **American Academy of Neurology** is a non-profit organization of approximately 14,000 neurologists who practice throughout the United States and beyond. The Academy strives to serve the broad educational needs of its members; to encourage the highest standards of clinical care, education, and research in the field of neurology; and to advance the specialty of neurology and the well-being of those served by it. The Academy has taken a leadership role in developing substantive and procedural

guidelines for patient care and decision-making in such circumstances as persistent vegetative state, advanced dementia, profound and irreversible paralysis ("locked-in syndrome"), and anencephaly.

The **American Neurological Association** was founded in 1875 and today represents over 1,100 academic neurologists.

The **American Society of Anesthesiologists** was founded in 1905 in New York and currently has more than 34,000 members. It is a scientific and educational association of anesthesiologists that was organized to advance the practice of anesthesiology and to improve the quality of care of the anesthetized patient. It is the largest organization of anesthesiologists in the world.

The **American Society of Clinical Pathologists (ASCP)** is a non-profit medical specialty society organized for educational and scientific purposes. The 75,000 members of the ASCP include board certified pathologists, other physicians, clinical scientists, and certified technologists and technicians. These professionals recognize the Society as the principal source of continuing education in pathology and as the leading organization for the certification of laboratory personnel. ASCP's certifying board registers more than 150,000 laboratory professionals annually.

The **College of American Pathologists (CAP)** is a medical society serving more than 15,000 physician members and the laboratory community throughout the world. Incorporated in 1947, the College is a not-for-profit organization. CAP is the world's largest association composed exclusively of pathologists and is widely considered to be the leader in laboratory quality assurance. The CAP is an advocate for high quality and cost-effective patient care. The mission of the College is to represent the interests of patients, the public and pathologists by fostering excellence in the practice of pathology worldwide.

The **American Society of Abdominal Surgeons (ASAS),** founded in 1959, is a private, voluntary, non-profit organization of physicians. Its mission is to develop a strong continuing surgical education program for the unique specialty of abdominal surgery. The 4,000 members of the ASAS practice in all states, Canada, and Mexico.

The **American Association of Clinical Endocrinologists (AACE)** is an international medical association devoted to the field of clinical endocrinology. Its more than 2,500 members are physicians with special education, training and interest in the practice of endocrinology. AACE members are clinicians and educators in areas such as diabetes, thyroid illnesses, lipid profiles, reproductive disorders, obesity, and nutrition.

The **California Medical Association (CMA)** is a non-profit, incorporated professional association of approximately 33,000 physicians practicing in the State of California. The CMA is the largest state medical association in the country, and the membership includes most California physicians engaged in the private practice of medicine, in all specialties. CMA's primary purposes are " . . . to promote the science and art of medicine, the care and well-being of patients, the protection of public health, and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.

The **Medical Society of the State of New York** was organized in 1807 and is incorporated and operated under the state's Not-for-Profit Corporation Law. The Society has approximately 27,000 member physicians, representing physicians in all specialties. The purposes of the Medical Society include: "To enhance the delivery of medical care of high quality to all people in the most economical manner, and to act to promote and maintain high standards in medical education and in the practice of medicine in an effort to ensure that quality medical care is available to the public."

The **Medical Association of the State of Alabama** is a non-profit professional association of licensed physicians representing 5,600 members in the State. The Association was founded in 1873 and it is the premiere medical professional association in the State of Alabama.

The **Arkansas Medical Society** organized in 1875, is a non-profit, professional organization representing 3,857 licensed physicians in the State of Arkansas.

The **Medical Association of Georgia,** formed in 1849, is a non-profit professional association of approximately 7,500 licensed physicians who provide patient care in all aspects of medical practice in the State of Georgia.

The **Illinois State Medical Society** is a non-profit professional association of licensed physicians, residents and medical students, founded in 1840, and representing more than 18,000 members in the State of Illinois.

The **Indiana State Medical Association** is a non-profit, professional association of licensed physicians founded in 1849, and representing 7,200 physicians in all areas of medical practice in the State.

The **Iowa Medical Society** is a non-profit, professional association of licensed physicians founded in 1860, and representing 4,000 physicians in all areas of medical practice in the State.

The **Louisiana State Medical Society,** founded in 1878 and representing 6,340 physicians and medical students in Louisiana, is a non-profit, tax-exempt professional association. The Louisiana State Medical Society provides leadership for the advancement of the health of the people of Louisiana and is the premier advocate in Louisiana for patients and physicians.

The **Massachusetts Medical Society** is the oldest, continuous non-profit, professional medical association in the United States. Founded in 1781, it represents approximately 16,000 members in the State.

The **Mississippi State Medical Association** is a private, voluntary, non-profit organization, which was founded in 1856 to promote the extension of medical knowledge, the advancement of medical science, the elevation of the standard of medical education, the enactment of just medical laws and the improvement of public health. The Association's membership consists of approximately 3,000 physicians licensed to practice medicine in the State of Mississippi.

The **Missouri State Medical Association** is a non-profit professional association of physicians licensed to practice medicine in Missouri and students training in the state's accredited medical schools. The Missouri State Medical Association was founded in 1850 and currently represents and serves approximately 6,300 members.

The **Montana Medical Association** is a non-profit organization comprised of physician members. The Association was chartered in 1878 and represents 960 licensed physicians in the State of Montana.

The **Nebraska Medical Association** is a non-profit, professional association of licensed physicians founded in 1868, and representing 1,952 members in the State.

The **Medical Society of New Jersey** is the nation's first medical society, founded in 1766. With more than 9,500 physician members, the Society is the State's leading voice in the health care field. The Society's mission is to promote the quality of New Jersey health care and health services for all of the citizens of the state through leadership and assistance to its physician members.

The **New Mexico Medical Society** is a non-profit, professional association of licensed physicians founded over 100 years ago, and representing 2,800 members in the State.

The **North Carolina Medical Society** is a non-profit, professional association which represents physicians in North Carolina and has approximately 9,000 members. The Society was incorporated by an Act of the North Carolina General Assembly in 1858.

The **Ohio State Medical Association (OSMA)** is a non-profit professional association of approximately 16,000 physicians, medical residents and medical students. OSMA's membership includes physicians in all specialties engaged in the private practice of medicine in the State of Ohio. OSMA's purposes are to: improve public health through education, encourage interchange of ideas among members and maintain and advance the standards of practice by requiring members to adhere to the concepts of professional ethics.

The **Tennessee Medical Association** is a non-profit corporation formed in 1830 and is composed of approximately 6,800 medical doctors licensed in Tennessee, including medical students and medical residents seeking licensure.

The **Texas Medical Association** is a private, voluntary, non-profit organization of physicians founded in 1853 to serve the people of Texas in matters of medical care, prevention and cure of disease, and the improvement of public health. It has aproximately 34,000 members representing 84% of all licensed physicians practicing in Texas.

The **Vermont Medical Society** is a non-profit professional association of licensed physicians. The Society was founded in 1784 and represents over 1,100 members.

The **Medical Society of the State of Virginia** is a not-for-profit professional association of over 6,500 member physicians representing every medical specialty and proportionally represented throughout Virginia. The mission of the Society is to: preserve, defend and enhance the doctor-patient relationship; promote better health and health care for all Virginians; support the discovery and dissemination of new knowledge of human death and disease; and in all these things to articulate the position of organized medicine, consistent with the highest standards of the medical profession.

The **West Virginia Medical Association,** founded in 1867, is a non-profit professional Association of licensed physicians and represents 2,100 members in the State.

The **Society of Medical Consultants to the Armed Forces** was formed in 1946. The goals of the society include: assisting in the development and maintenance of the highest standards of medical practice in the Armed Forces; and providing advice and assistance to the Surgeons' General on problems of professional importance in the Armed Forces.

The **American Institute of Life-Threatening Illness and Loss,** a division of the Foundation of Thanatology which was incorporated in 1967 in the State of New York, is dedicated to promoting vastly improved psychosocial and medical care for patients critically ill or dying from (among multiple diseases) cancer, heart disease, AIDS, stroke, end stage renal disease, and emphysema. A major emphasis of the Foundation is on medical education and quality of life studies. Over the past 25 years, the Foundation has held over 115 national symposia and published over 115 related books.

The **National Hispanic Council on Aging** is a private organization that works to promote the well-being of older Hispanics. It was founded in 1980, and there are approximately 5,000 members throughout the United States, Puerto Rico, and Mexico.

APPENDIX B

OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS AMERICAN MEDICAL ASSOCIATION

Opinion 2.211—Physician Assisted Suicide. Physician-assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress, such as those suffering from a terminal, painful, debilitating illness, may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Multidisciplinary interventions should be sought including specialty consultation, hospice care, pastoral support, family counseling, and other modalities. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993; Updated June 1996. (I, IV)

Opinion 2.20—Withholding or Withdrawing Life-Sustaining Medical Treatment. The social commitment of the

physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forgo life-sustaining treatment of a patient who possesses decisionmaking capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision. A patient may also appoint a surrogate decisionmaker in accordance with state law.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decisionmaker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates. Physicians should provide all relevant medical information and explain to surrogate decisionmakers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences and values. In making a substituted judgment, decisionmakers may consider the patient's advance directive (if any);

the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should always be accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the decisionmaking process: (a) there is no available family member willing to be the patient's surrogate decisionmaker, (b) there is a dispute among family members and there is no decisionmaker designated in an advance directive, (c) a health provider believes that the family's decision is clearly not what the patient would have decided if competent, and (d) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family health care providers, the use of ethics committees specifically designed to facilitate sound decisionmaking is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing palliative treatment even though it may foreseeably hasten death.

Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis. Issued March 1981 (Opinion 2.11: Terminal Illness) and December 1984 (Opinion 2.19: Withholding or Withdrawing Life-Prolonging Medical Treatment: Patient's Preferences). Updated June 1994 based on the reports "Decisions Near the End of Life" and "Decisions to Forgo Life-Sustaining Treatment for Incompetent Patient," both issued June 1991; and Updated June 1996. (I, III, IV, V)

Opinion 2.22—Do-Not-Resuscitate Orders. Efforts should be made to resuscitate patients who suffer cardiac or respiratory arrest except when circumstances indicate that cardiopulmonary resuscitation (CPR) would be inappropriate or not in accord with the desires or best interests of the patient.

Patients at risk of cardiac or respiratory failure should be encouraged to express in advance their preferences regarding the use of CPR and this should be documented in the patient's medical record. These discussions should include a description of the procedures encompassed by CPR and, when possible, should occur in an outpatient setting when general treatment preferences are discussed, or as early as possible during hospitalization. The physician has an ethical obligation to honor the resuscitation preferences expressed by the patient. Physicians should not permit their personal value judgments about quality of life to obstruct the implementation of a patient's preferences regarding the use of CPR.

If a patient is incapable of rendering a decision regarding the use of CPR, a decision may be made by a surrogate decisionmaker, based upon the previously expressed preferences of the patient or, if such preferences are unknown, in accordance with the patient's best interests.

If, in the judgment of the attending physician, it would be inappropriate to pursue CPR, the attending physician may enter a do-not-resuscitate (DNR) order into the patient's record. Resuscitative efforts should be considered inappropriate by the attending physician only if they cannot be expected either to restore cardiac or respiratory function to the patient or to meet established ethical criteria, as defined in the Principles of Medical Ethics and Opinions 2.03 and 2.095. When there is adequate time to do so, the physician must first inform the patient, or the incompetent patient's surrogate, of the content of the DNR order, as well as the basis for its implementation. The physician also should be prepared to discuss appropriate alternatives, such as obtaining a second opinion (e.g., consulting a bioethics committee) or arranging for transfer of care to another physician.

DNR orders, as well as the basis for their implementation, should be entered by the attending physician in the patient's medical record.

DNR orders only preclude resuscitative efforts in the event of cardiopulmonary arrest and should not influence other therapeutic interventions that may be appropriate for the patient. Issued March 1992 based on the report "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," issued December 1990. Updated June 1994. (I, IV)

Opinion 2.035—Futile Care. Physicians are not ethically obligated to deliver care that, in their best professional judgment, will not have a reasonable chance of benefiting their patients. Patients should not be given treatments simply because they demand them. Denial of treatment should be justified by reliance on openly stated ethical principles and acceptable standards of care, as defined in opinions 2.03 and 2.095, not on the concept of "futility," which cannot be meaningfully defined. Issued June 1994. (I, IV)

Opinion 2.21—Euthanasia. Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. Issued June 1994 based on the report "Decisions Near the End of Life," issued June 1991; Updated June 1996. (I, IV)

Opinion 2.06—Capital Punishment. An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into

one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical diagnoses as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying to the medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned

person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner to restore competence unless a commutation order is issued. However, if the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. Provision of medical testimony in the reevaluation of the prisoner's legal competence to be executed should be provided by an independent physician examiner. A physician cannot be compelled to provide medical testimony as it relates to legal competence for execution if it is contrary to the physician's personal beliefs.

Organ donation by condemned prisoners is permissible only if (1) the decision to donate was made before the prisoner's conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation. Issued July 1980. Updated June 1994 based on the report "Physician Participation in Capital Punishment," issued December 1992 (JAMA. 1993; 270: 365-368), and updated June 1996 based on the report "Physician Participation in Capital Punishment: Evaluations of Prisoner Competence to be Executed; Treatment to Restore Competence to be Executed," issued in June 1995. (I)

APPENDIX C

AMERICAN NURSES ASSOCIATION

CODE FOR NURSES WITH INTERPRETIVE STATEMENTS

1.1 Respect for Human Dignity

* * * Clients have the moral right to determine what will be done with their own person; to be given accurate information, and all the information necessary for making informed judgments; to be assisted with weighing the benefits and burdens of options in their treatment; to accept, refuse, or terminate treatment without coercion; and to be given necessary emotional support.

* * * *

POSITION STATEMENT ON ASSISTED SUICIDE

SUMMARY: The American Nurses Association (ANA) believes that the nurse should not participate in assisted suicide. Such an act is in violation of the *Code for Nurses with Interpretive Statements (Code for Nurses)* and the ethical traditions of the profession. Nurses, individually and collectively, have an obligation to provide comprehensive and compassionate end-of-life care which includes the promotion of comfort and the relief of pain, and at times, foregoing life-sustaining treatments.

* * * *

POSITION STATEMENT ON PROMOTION OF COMFORT AND RELIEF OF PAIN IN DYING PATIENTS

Summary: The American Nurses Association (ANA) believes that the promotion of comfort and aggressive efforts to relieve pain and other symptoms in dying patients are

obligations of the nurse. Nurses should not hesitate to use full and effective doses of pain medication for the proper management of pain in the dying patient. The increasing titration of medication to achieve adequate symptom control, even at the expense of life, thus hastening death secondarily, is ethically justified.

* * * *

POSITION STATEMENT ON ACTIVE EUTHANASIA

SUMMARY: The American Nurses Association (ANA) believes that the nurse should not participate in active euthanasia because such an act is in direct violation of the *Code for Nurses with Interpretive Statements (Code for Nurses),* the ethical traditions and goals of the profession, and its covenant with society. Nurses have an obligation to provide timely, humane, comprehensive and compassionate end-of-life care.

* * * *

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No. 95-1858

IN THE
Supreme Court of the United States
OCTOBER TERM, 1996

DENNIS C. VACCO, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, *et al.*,
Respondents.

On Writ of Certiorari To The United States
Court of Appeals For The Second Circuit

BRIEF OF CLARENDON FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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November 12, 1996

31 pp

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTEREST OF *AMICUS CURIAE* 1

SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. THE LOWER COURTS RELIED ON QUESTION-BEGGING CHARACTERIZATIONS OF THE RELEVANT LEGISLATIVE CLASSES 4

II. POSSIBLE GROUNDS FOR DISTINGUISHING THE CLASSES AT ISSUE IN THIS CASE 5

III. WHILE REFUSAL OF TREATMENT DOES NOT REQUIRE THAT A PATIENT BE IDENTIFIED AS TERMINALLY ILL, ASSISTED SUICIDE DOES REQUIRE SUCH A DETERMINATION 10

IV. WHILE THE REFUSAL OF TREATMENT IMPLICATES THE RIGHT TO BE FREE FROM UNWANTED BODILY INVASIONS, ASSISTED SUICIDE DOES NOT IMPLICATE THIS RIGHT 15

CONCLUSION 18

TABLE OF AUTHORITIES

CASES

Bowen v. Owens, 476 U.S. 340 (1986) 4

Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1985) 3

Quill v. Koppell, 870 F. Supp. 78 (S.D.N.Y. 1994) 5

Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) . . . . . *passim*

OTHER MATERIALS

R. DWORKIN, N.Y. REV. OF BOOKS (Aug. 1996) 16

R. ROTUNDA & J. NOWAK, TREATISE ON CONSTITUTIONAL LAW (2d ed. 1992) 3

B. STEINBOCK, KILLING AND LETTING DIE (1980) 7,8

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1858

DENNIS C. VACCO, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, *et al.*,
Respondents.

On Writ of Certiorari To The United States Court of Appeals For The Second Circuit

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BRIEF OF CLARENDON FOUNDATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF *AMICUS CURIAE*

Pursuant to Rule 37.3 of this Court, Clarendon Foundation respectfully submits this brief *amicus curiae* in support of Petitioners. Written consent to the filing of this brief has been granted by counsel for all parties. The letters of consent have been lodged with the Clerk. Clarendon Foundation is a nonprofit, nonpartisan legal foundation concerned with significant issues related to the Constitution and democratic government. The Foundation participates in various forums in cases where the resolution of constitutional

issues implicates basic rights. The organization is committed to an ongoing review of the tenets of our constitutional government, in the spirit of George Mason's admonition that ". . . no free government, or the blessings of liberty, can be preserved to any people, but . . . by frequent recurrence to fundamental principles." George Mason, THE VIRGINIA DECLARATION OF RIGHTS, *reprinted in* 1 THE PAPERS OF GEORGE MASON, 1725-1792, at 278 (R. Rutland ed. 1970). Because this case raises a question of paramount significance to the public interest, we believe our perspective will complement the brief of Petitioners and assist the Court in the resolution of this matter.

SUMMARY OF ARGUMENT

Decisions regarding the end of life present some of the most challenging constitutional and ethical questions that this Court ever addresses. In *Vacco v. Quill*, No. 95-1858, and *Washington v. Glucksberg*, No. 96-110, the Court considers whether a state may ban voluntary assisted suicide for patients suffering from terminal illness. Two constitutional arguments against such a ban are before the Court. One is whether the Fourteenth Amendment, as a matter of substantive due process, includes the right of terminally ill patients to commit suicide (and further, a right of doctors to assist such patients in carrying out their wishes). We take no position on that question. Instead, we direct our analysis to the argument on which the Second Circuit based its holding in *Quill v. Vacco*: that the New York statute banning assisted suicide violates the Fourteenth Amendment's Equal Protection Clause because it "does not treat similarly circumstanced persons alike." *Quill v. Vacco*, 80 F. 3d 716, 729 (2nd Cir. 1996). For several

reasons, we urge the Court to reject this argument and reverse the Second Circuit's holding.

At the outset, it is essential to avoid the temptation to rely on question-begging characterizations of the classes at issue. Instead, we should look directly at the grounds upon which the classification in question might be thought to rest. In the case of the New York statute at issue here, there are a variety of such grounds. The most obvious is the difference between acts and omissions. This approach, however, while it has surface appeal, raises philosophical issues that undermine its value. Other bases for a legislative classification are more compelling. The State has legitimate interests in preventing patients who have been misdiagnosed as terminally ill from suffering a premature death, in preventing fraudulent certification of patients as terminally ill, in avoiding the difficult philosophical questions involved in defining 'terminal illness', and in protecting people from unwanted physical invasions. All of these interests are served by distinguishing the two classes. Thus, on any of these grounds, the New York statute passes muster under the Equal Protection Clause.

ARGUMENT

The Fourteenth Amendment's Equal Protection Clause requires the government to treat similarly situated people equally. *See* 3 RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW § 18.2, at 7 (2d ed. 1992). State legislation generally carries a presumption of constitutional validity if the statutory classification is "rationally related to a legitimate state interest." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1985). Social welfare legislation, such as New York's

statutory ban on assisted suicide, needs only to survive rational basis scrutiny to withstand a challenge under the Fourteenth Amendment's Equal Protection Clause. *See Bowen v. Owens*, 476 U.S. 340, 345 (1986).

I. THE LOWER COURTS RELIED ON QUESTION-BEGGING CHARACTERIZATIONS OF THE RELEVANT LEGISLATIVE CLASSES

In this case, the classes in question — those who refuse or wish to be withdrawn from medical treatment and those who desire a physician's help in killing themselves — have a significant feature in common. Both involve people who wish to end their lives as a means to ending their suffering.[1] But, just as clearly, there are also notable differences between the two classes. In one case, the goal can be achieved merely by withdrawing or withholding treatment. In the other, more direct measures must be taken to end the patient's life. Given these similarities and differences between the two classes, one must avoid the temptation to adopt question-begging characterizations of them — characterizations that emphasize either the similarities or the differences merely in order to set the stage for a pre-chosen conclusion to be drawn.

For example, those who wish to treat the classes *alike* emphasize the similarities, pointing out that both consist of

[1] It is worth noting, however, that many people refuse treatment even absent a desire to die. For example, some view extraordinary attempts to prolong life as undignified, even though they would prefer, other things being equal, to live longer.

people wishing to "hasten death." Thus, Judge Miner of the Second Circuit asserts:

> [I]t seems clear that New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to *hasten their deaths* by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to *hasten death* by self-administering prescribed drugs.

Quill v. Vacco, 80 F. 3d 716, 729 (emphasis added). By contrast, the district court uses words like "natural" and "artificial" to emphasize the *differences* between the two classes: "It is hardly unreasonable or irrational for the State to recognize a difference between *allowing nature to take its course*, even in the most severe situations, and *intentionally using an artificial death-producing device*." *Quill v. Koppell*, 870 F. Supp. 78, 84-85 (S.D.N.Y. 1994) (emphasis added). In both cases, the chosen terminology simply masks a predisposition to find similarities or differences between the two classes. The critical question, therefore, is whether the differences between the classes are rationally related to a legitimate state interest.

II. POSSIBLE GROUNDS FOR DISTINGUISHING THE CLASSES AT ISSUE IN THIS CASE

(1) *The Act/Omission Distinction.* On what basis might a state rationally distinguish between those patients

identified as terminally ill, whom the law permits to refuse life-saving medical care, and those who wish assistance in killing themselves? An obvious starting point is the distinction between acts and omissions or, more specifically, between killing and letting die. Attempts to rely on the act/omission distinction in this context raise two separate questions. *(A)* Is it really true that a doctor who, at the patient's request, withdraws treatment (or withholds treatment) is merely committing an omission (and hence "letting die"), while one who prescribes a lethal dose of medication is acting affirmatively (and hence killing)? And, *(B)* if so, is there any rational basis for thinking that a legitimate state purpose could be furthered by drawing a distinction between killing and letting die in circumstances like those presented in this case?

(A) Is This An Act/Omission Case? This question is difficult to answer. Once again, there are both similarities and differences between removing a patient from life support and administering lethal drugs, and interested parties will characterize the conduct as active or passive depending on how they want the argument to turn out. Those wishing to deny the force of the distinction can point to elements of activity in the behavior associated with withholding or terminating treatment. For example, disconnecting a patient from life support systems involves action, and such action might in certain cases be thought more significant than that involved in the writing of a prescription for a lethal dosage of drugs. Judge Miner's opinion highlights this similarity between the two sorts of cases:

> Moreover, the writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician

> than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.

Quill v. Vacco, 80 F.3d 716, 729. On the other hand, there is much to be said for the common sense view that terminating treatment is merely "leaving a patient alone," while administering a lethal injection is "doing something to the patient." It is thus not surprising that those wishing to rely on the distinction favor this sort of description.

(B) Is The Act/Omission Distinction Morally Relevant? There is certainly a long tradition of support for this distinction in ordinary moral thought.[2] Yet the distinction

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[2] Professor Bonnie Steinbock points to three places in which the moral significance of the distinction appears to be acknowledged:

> [I]t is clearly against the law to kill another person (with certain exceptions, such as self-defense); and with certain exceptions, the law is indifferent to letting die. Secondly, the Sixth Commandment explicitly prohibits killing (or wrongful killing) but is silent about letting die. And while the Hippocratic Oath explicitly enjoins doctors from giving deadly medicine to anyone, it does not provide clear guidance concerning when treatment may be omitted and a patient allowed to die. In these three areas, then—law, religion, and medicine—the moral significance of the killing/letting die distinction seems to be upheld. B STEINBOCK, KILLING AND LETTING DIE (1980) at 2.

has also been the frequent subject of philosophical criticisms. *See, e.g.*, Michael Tooley, "An Irrelevant Consideration: Killing Versus Letting Die," and James Rachels, "Active And Passive Euthanasia," at 56, 63 in B. STEINBOCK, KILLING AND LETTING DIE, *supra*. Typically, the counter-argument is that other factors which commonly correlate with killing or letting die carry all of the moral weight; the bare distinction between killing and letting die is by itself morally insignificant. As Professor Steinbock observes:

> Most philosophers who question the moral significance of the killing/letting die distinction are not denying that often it does make a difference. Rather, they maintain that it is certain features usually connected with, but not essential to the distinction which make the moral difference. One of these features is the *motivation* of the agent. The motivation of a person who kills someone is generally, though not always, more evil than the motivation of a person who merely lets someone die. Another feature is *certainty of the outcome*. A death is usually more certain if one is trying to kill than if one is merely refraining from preventing a death.

Id. at 2. Likewise, it often takes a good deal more effort to save a person's life than it would to refrain from killing him. Thus, it is sometimes argued, we have less responsibility to save lives than we do to avoid killing people, since saving lives asks more of us than refraining from killing. And similarly, it

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is claimed that the difference between good and bad intentions is what, in certain cases at least, makes the moral difference between killing and letting die.

(2) *The Act/Omission Analysis Is Unnecessary To Resolve This Case*. In both cases discussed above it is possible to analytically "bracket" certain factors in order to ask whether there is any difference between "pure" killing and "pure" letting die. This bracketing allows the philosopher to isolate other factors, in particular the distinction between killing and letting die, in order to test for their moral significance *eo ipso*. To bracket the issue of intentions, the philosopher can ask us to consider a hypothetical case in which the intentions are stipulated to be identical. To bracket the question of effort, the philosopher can focus on a hypothetical case involving (nearly) effortless saving.

But a legislature is not in a position to rely on philosophically pure categories or hypothetical cases when it formulates social policy. Instead it must look to the circumstances of the thousands of real people who will actually be affected by its decisions. What it is possible to do in theory may be impossible or extraordinarily costly to do in practice. In theory it may be possible to distinguish "pure" cases of killing from "pure" cases of letting die; in practice the cases are rarely, if ever, so pure. Real people come with real circumstances, which are generally messy by theoretical standards. It is enough, in the context of legislation, if in the real cases likely to fall under the legislation, the two classes are *generally* correlated with morally relevant differences. The classes at issue in this case meet this requirement.

Thus, it is not really essential to decide whether the withdrawal or withholding of treatment constitutes an act or an omission, whether the sort of assisted suicide at issue in this case is more or less active than that withdrawal or withholding, or even whether the act/omission distinction itself is morally significant. We know enough about the two classes to see that there are *often* morally relevant distinctions between them, regardless of how they are characterized. These differences, set forth below, give a rational basis for distinguishing between the two classes, in the furtherance of legitimate state interests.[3]

III. While Refusal Of Treatment Does Not Require That A Patient Be Identified As Terminally Ill, Assisted Suicide Does Require Such A Determination

We are told that both classes involve terminally ill patients. But what we are actually confronted with is not terminally ill patients, but patients *identified* by someone as terminally ill. The distinction is subtle, but is of the highest importance, since the possibility of misidentification has decidedly different impacts on the two classes.

A. The State Has A Legitimate Interest In Protecting Patients Who Have Been Misdiagnosed As Terminally Ill From Premature Death. One example of such a legally

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[3] The Second Circuit opinion argues that many putative distinctions between the classes do not in fact serve any legitimate state interest. But even if this were correct, the fact that certain interests are not served does *not* undermine the claim that other legitimate interests are served by drawing the distinction in question.

relevant differential impact concerns honest mistakes in identifying patients with terminal illness. We are all familiar with stories about people who are told that they have only a short period to live, but who nevertheless fully recover from their illness. In a withholding of treatment case, it would appear, a patient who has been misidentified as terminally ill simply goes on living. By contrast, in an assisted suicide case, a patient who is not terminally ill nevertheless dies. The State has a clear and legitimate interest in preventing such patients from dying.

Is it really true, however, that a patient who has been misidentified as terminally ill goes on living when treatment is withheld? The answer depends on what we mean by 'terminally ill'. On a narrower interpretation, a person is terminally ill only if he has an untreatable, deadly condition. On a broader interpretation, a patient is also terminally ill if he would die if left untreated, but would live if the treatment were provided.

Which interpretation of 'terminally ill' should we accept? On the narrower interpretation, a patient with late-stage pancreatic cancer who is beyond any possibility of benefit from surgery, chemotherapy, or radiation would be considered terminally ill, but a patient with early-stage melanoma whose life could be extended substantially by a simple surgery would not. On the second interpretation, the melanoma patient would be considered terminally ill as well. But so would a patient who, after recovering from throat surgery, requires intravenous feeding and hydration for a week or more, since this patient would die if the treatment were

withheld.[4] And so also would a patient suffering from a serious infection, for which a reliable antibiotic is readily available. Yet calling such patients terminally ill seems clearly to be a mistake. Thus, the narrower interpretation of 'terminal illness' comes closer to matching our intuitions about its meaning and extension.

With this in mind, what can we say about a patient who has been misidentified as terminally ill? Is it true that such a patient "simply goes on living" if treatment is withheld? Consider the following two cases: Case 1 involves a patient whom we mistakenly believe needs treatment (say, surgery) in order to survive. We withhold the treatment, but the patient lives. Had we actively terminated his life (for example, by administering a lethal dose) he would have died. This appears to be the sort of case imagined above, in which the State's interest in preventing unnecessary death is implicated. Had assisted suicide been forbidden but refusal of treatment allowed, the patient would have continued to live.

Note, however, that we would not have thought of this patient as terminally ill in the ordinary sense of the word. He is thought to be terminally ill only in the broader sense that he will die if he does not receive the treatment, but not if he does receive it. Since the claimed right to assisted suicide applies only to patients identified as terminally ill, assisted suicide would be allowed in cases like this only if we were to adopt

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[4] This example assumes, as we have assumed throughout, that "treatment" includes the provision of life-sustaining food and hydration. This assumption seems reasonable, given that the right to refuse treatment includes the right to refuse the forced provision of these (and other) necessities.

the broader, but less plausible, definition of 'terminal illness'. If instead we were to adopt — as we should — the narrower interpretation, assisted suicide would not be an issue in cases like this, since the patient would not be considered terminally ill. And if not, then the case does not support the claimed distinction between refusal of treatment and assisted suicide.

But now consider a second case. Case 2 involves a patient who is misidentified as terminally ill in the narrower, and more plausible, sense that she will die whether or not she receives treatment. Here what happens to the patient will depend on the sort of withdrawal or withholding of treatment we have in mind. If such a patient chooses to starve herself to death, no doubt she can do so, and she can guarantee her death just as surely as she could by taking a lethal dose. But, as noted earlier, death by starvation can be protracted and painful, and many patients will not choose to undergo it even if they have a sincere wish to die. If the patient does not choose to starve herself to death, and if she has been misidentified as terminally ill, then she will live unless she takes active measures to end her own life. A state has a clear and legitimate interest in protecting a patient such as this from suffering a premature death.

B. The State Has A Legitimate Interest In Preventing Fraudulent Certifications Of Terminal Illness. In any event, there are simpler arguments for treating the two classes differently, and any one of them is sufficient to undermine the equal protection argument. A second argument is based on the fact that fraud is more likely to occur in assisted suicide cases than in withholding of treatment cases. Some people wish to extend the right to die beyond the class of terminally ill patients. It is not uncommon to encounter doctor-assisted

suicides involving patients with multiple scleroses, the early stages of Alzheimer's disease, chronic pain, and other maladies not likely to lead to death in the short run. A doctor who wishes to aid such patients can fraudulently certify that the patient is terminally ill and then help him commit suicide. Detecting the subterfuge will be rendered unlikely by the death of the doctor's only witness. But such a doctor cannot end the life of a person who is not terminally ill simply by withholding treatment. The State has a legitimate interest in preventing fraud and may have an interest in preventing persons who are not terminally ill from taking their own lives.

C. The State Has a Legitimate Interest In Avoiding Difficult Questions Involved In Defining Terminal Illness.

A related issue concerns further difficulties in specifying what is meant by 'terminally ill'. It is often said that we are all terminally ill; some of us just have longer to live than others. Although this is hyperbole, it is related to an important point: It is very difficult to specify what is meant by 'terminal illness' in order to draw a line between those who have a right to assisted suicide and those who do not. One area of difficulty concerns the proximity of death. Is a patient with early-stage prostate cancer terminally ill, even though death due to that form of cancer may be very far off, and a high percentage of such patients die of other causes before the cancer advances to the point where it actually leads to death? Another difficulty relates to the probability that death will occur. The judgment that a patient is terminally ill is of necessity a probabilistic one. If patients had a constitutionally-protected right to assisted suicide, a serious issue would arise regarding how certain a doctor must be before he can declare a patient's illness terminal. A state could reasonably choose to avoid these vexing issues by drawing a bright line between the

withholding of treatment and assisted suicide, since in the former cases no determination that a patient is terminally ill needs to be made.

* * *

Before considering another possible distinction between the two classes at issue here, one final point about our analysis thus far is in order. The very complexity of the issue should give the Court pause before deciding this case against New York on equal protection grounds. The equal protection argument raises difficult questions of fact, involving among other things, predictions about the consequences of various suggested policies. How many patients would actually choose to starve themselves to death? Is there a substantial number of patients who would decline to do so but would choose assisted suicide if offered the option? How frequently does accidental misdiagnosis of terminal illness occur? Questions like these are best left to the legislative branch, which has better information-gathering resources than the judiciary, and a greater ability to change its mind if things turn out differently than expected.

IV. While The Refusal Of Treatment Implicates The Right To Be Free From Unwanted Bodily Invasions, Assisted Suicide Does Not Implicate This Right

A final basis for distinguishing assisted suicide from withdrawal of life support cases has been raised by Professor Ronald Dworkin. The State has a special interest in protecting an individual's right to be free from unwanted bodily invasions. But this right is not a right to have one's body treated in whatever way one wishes. It is one thing to say that an

individual has "a right to be left alone." It is quite a different matter to say that an individual has a right to receive a certain sort of treatment merely because he desires it:

> A right to prevent or stop treatment is part of a more general constitutionally protected right not to suffer unwanted invasions of one's body. But that more general right does not include a right that invasions the patient desires, like lethal pills or injections, be provided—otherwise it would include a constitutional right for everyone to take narcotic drugs, for example.

R. Dworkin, N.Y. REV. OF BOOKS (Aug. 1996) at 45-46. Here again, the distinction between the two classes can rationally be thought to further a legitimate state interest. This time the interest lies in protecting people from unwanted physical invasions — an interest not present in assisted suicide cases.

* * *

Of course, the similarities between the two classes are not irrelevant to constitutional analysis simply because they do not support an equal protection argument. Indeed, it might be thought that whatever constitutionally cognizable interest is served by allowing patients to decline treatment, is indeed hard to distinguish from the similar interest of patients seeking active assistance. Both situations implicate significant concerns about autonomy and privacy, and involve matters of fundamental importance to the conduct of people's lives. Thus, it is possible that a constitutional right to assisted suicide could be inferred from the same provisions that support a right to decline treatment. However, we take no

position on such arguments here. Instead, we believe that the Court cannot bypass this difficult issue by relying, as did the Second Circuit, on a shaky equal protection argument. If there is a constitutional right to assisted suicide, that right must be grounded elsewhere.

CONCLUSION

For the foregoing reasons the decision of the Second Circuit should be reversed.

Respectfully submitted,

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IN THE

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OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF THE MEDICAL SOCIETY OF NEW JERSEY AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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41pp

TABLE OF CONTENTS

	PAGE
TABLE OF AUTHORITIES	iii
INTEREST OF THE *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	3
I. THE ETHOS OF MEDICINE DOES NOT COUNTENANCE ASSISTANCE IN SELF-DESTRUCTION	3
A. History and Tradition Forbid Physician Assistance in Patient Suicide	3
B. Decisions To Forego Life-Sustaining Treatment Are Profoundly Separate from Elections To Assist in Patient Self-Destruction	6
II. STATES HAVE THE CONSTITUTIONAL COMPETENCE TO PROHIBIT ASSISTANCE IN SELF-DESTRUCTION	10
A. New Jersey Has a Rich Juridical and Legislative Tradition Regarding Patient Autonomy in Treatment Decisions, Which Explicitly Rejects the Concept of Physician Assisted Self-Destruction	11
B. Past Pronouncements of This Court Inform and Authenticate Prohibitions Against Assistance in Self-Destruction	15

PAGE

CONCLUSION 17

APPENDIX A 1a-3a

APPENDIX B 1b-2b

APPENDIX C 1c-3c

APPENDIX D 1d

APPENDIX E 1e

APPENDIX F 1f-3f

APPENDIX G 1g

TABLE OF AUTHORITIES

Cases PAGE

Bartling v. Superior Court,
163 Cal. App.3d 186, 209 Cal. Rptr. 220
(Cal. Ct. App. 1984) 14

Blackburn v. State,
23 Ohio St. 146 (Ohio 1972) 17

Brophy v. New England Sinai Hosp.,
398 Mass. 417, 497 N.E.2d 626 (1986) ..... •14

Commonwealth v. Mink,
123 Mass. 422 (Mass. 1877) 16

Cruzan v. Director, Missouri Health Dept.,
497 U.S. 261 (1990) 15-16

Foody v. Manchester Memorial Hosp.,
20 Conn. Supp. 127, 482 A.2d 713
(Super. Ct. 1984) 14

In re Colyer,
99 Wash.2d 114, 660 P.2d 738 (1983) 14

In re Conroy,
98 N.J. 321, 486 A.2d 1209 (1985) 5, 6, 12-13

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52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266,
cert. denied, 454 U.S. 858 (1981) 14

In re Quinlan,
70 N.J. 10, 355 A.2d 647, *cert. denied*
sub nom. Garger v. New Jersey,
429 U.S. 922 (1976) 5, 6, 11-12

PAGE

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68 Ohio Misc. 1, 426 N.E.2d 809
(Ohio Com. Pl. 1980) 14

Matter of Farrell,
108 N.J. 335, 529 A.2d 404 (1987).....5, 13-14

Matter of Jobes,
108 N.J. 394, 529 A.2d 434 (1987) 5, 13

Matter of Peter by Johanning,
108 N.J. 365, 529 A.2d 319 (1987) 5, 13

People v. Kevorkian,
447 Mich. 436, 527 N.W.2d 714 (Mich. 1994) ... 16

Quill v. Vacco,
80 F.3d 716 (2d Cir. 1996)..... 2, 10

Satz v. Perlmutter,
362 So.2d 160 (Fla. Dist. Ct. App. 1978),
aff'd, 379 So.2d 359 (Fla. 1980) 14

State v. Jones,
86 S.C. 17, 67 S.E. 160 (S.C. 1910) 17

State v. Willis,
121 S.E.2d 854 (N.C. 1961) 17

Statutes

Ala. Code, § 13A-6-1 16

Alaska Stat., § 11.41.120(a)(2) 16

Ariz. Rev. Stat. Ann., § 13-1103(A)(3) 16

Ark. Stat. Ann., § 5-10-104(a)(2)..... 16

Cal. Pen. Code, § 401 16

PAGE

Colo. Rev. Stat., § 18-3-104(1)(b) 16

Conn. Gen. Stat., § 53a-56(a)(2)..... 16

Del. Code Ann., tit. 11, § 645..... 16

Fla. Stat. Ann., § 782.08 16

Ga. Code Ann., § 16-5-5(b) 16

Ill. Comp. Stat. ch. 720, 5/12-31 16

Ind. Stat. Ann., § 35-42-1-2.5(b) 16

Ia. Code, §§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session 16

Kan. Stat. Ann. § 21-3406 16

Ky. Rev. Stat., § 216:302..... 16

La. Rev. Stat., § 14:32.12 16

Me. Rev. Stat. Ann., tit. 17-A, § 204 16

Minn. Stat. Ann., § 609.215..... 16

Miss. Code Ann., § 97-3-49..... 16-17

Mo. Ann. Stat., § 565.023(1)(2) 17

Mont. Code Ann., § 45-5-105..... 17

Neb. Rev. Stat., § 28-307 17

N.H. Rev. Stat. Ann., § 630:4..... 17

N.J.S. 2C:11-6 14

N.J.S. 26:2H-53, *et seq.* 5, 14

N.J.S. 26:2H-54(d)..... 14-15

PAGE

N.J.S. 52:27G-5.1, *et seq.* 5

N.M. Stat. Ann., § 30-2-4 17

N.Y. Penal Law, §§ 120.30, 125.15(3) 17

N.D. Cent. Code., § 12.1-16-04 17

Okla. Stat. Ann., tit. 21, §§ 813-818 17

18 Pa. Cons. Stat. Ann., § 2502 17

P.R. Laws Ann., tit. 33, § 4009 17

S.D. Codified Laws Ann., § 22-16-37 17

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Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, Opinion 2.21, *Euthanasia* (1994) ... 9

PAGE

American Medical Association,
Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association, Opinion 2.211, *Physician Assisted Suicide* (1994) 4, 9

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PAGE

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

No. 95-1858

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF THE MEDICAL SOCIETY OF NEW JERSEY AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICUS CURIAE

Amicus Curiae, the Medical Society of New Jersey (MSNJ), respectfully submits this brief in support of the Petitioners. The MSNJ has obtained the written consent of both the Peti-

tioners and the Respondents to the filing of this brief *amicus curiae*.[1]

Founded in 1766, the MSNJ (our nation's first state society of physicians) is the primary organization of physicians in New Jersey. Approximately nine thousand five hundred physicians hold individual memberships in the MSNJ. For more than 230 years, the Medical Society of New Jersey has been the state's leading voice in the health care field. The MSNJ's mission is to promote the quality of health care and health services for all citizens of the state and to supply leadership and assistance to its physician members. To fulfill this mission the MSNJ regularly participates in important issues in the judicial, legislative and regulatory arenas.

The MSNJ has played a leadership role concerning contemporary legal and ethical issues confronting modern medical practice and has historically helped to shape and implement landmark judicial and legislative initiatives concerning life sustaining technologies and end of life decisionmaking. Through its Committee on Biomedical Ethics, the MSNJ has developed policies and positions addressing the roles of physicians, patients and hospitals and their concomitant rights, duties and obligations to the larger society physicians are privileged to serve.

As a leader in the health care field, as the representative of those physicians who bear the primary and sacred responsibility for the integrity of the medical profession, and as a contributor to the legal, medical and ethical debate, the MSNJ is vitally concerned about the lack of precedent, measure, balance and wisdom in the decision of the Second Circuit, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), legitimizing assistance in patient self-destruction. This ruling is clearly violative of the duties, prerogatives and responsibilities of the healing professions.

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[1] The letters providing consent from all parties have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

The physician members of the Medical Society of New Jersey, as pioneers in developing and guardians in the exercise of patients' rights,[2] submit that the past pronouncements of this Court justify state initiatives, which are informed and authenticated by the ethos of medicine, prohibiting assistance in patient self-destruction.

ARGUMENT

Informed, compassionate decision making routinely occurs within the physician-patient relationship. Since time out of memory, the ethical traditions of medicine have affirmed life as sacred and prohibited its taking. This Court should reject the Second Circuit's invitation to contemn the ancient canons of the healing arts.

I. THE ETHOS OF MEDICINE DOES NOT COUNTENANCE ASSISTANCE IN SELF-DESTRUCTION

A. History and Tradition Forbid Physician Assistance in Patient Suicide

The prohibition of physician assistance in patient self-destruction is as deeply rooted as any tradition defining the ethical practice of medicine. Ancient and contemporary medical canons have, for millennia, affirmed the sacredness of human life and enjoined purposeful medical assistance in killing the patient.

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[2] The MSNJ's position should not be interpreted in any way so as to compromise the ethically and legally protected right of terminally ill patients to participate fully in treatment decisions at the end of life, including the right to execute and implement advance directives and to refuse or request the withdrawal of aggressive forms of medical treatment which in the informed opinion of the patient impose burdens which outweigh the benefits. *See* Medical Society of New Jersey, *Statement on Physician Assisted Suicide*, App. A.

In 410 B.C., Hippocrates charged practitioners of the medical arts to ". . . give no deadly medicine to anyone if asked, nor suggest any such counsel."[3] Two thousand, four hundred and four years later, the American Medical Association affirmed this signal conviction in § 2.211 of its Code of Medical Ethics:

> **Physician Assisted Suicide.** Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide). It is understandable, though tragic, that some patients in extreme duress-such as those suffering from a terminal, painful, debilitating illness-may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.[4]

Mindful of its central role in helping to shape and implement several landmark judicial opinions and legislative

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[3] Hippocrates, The Oath (W.H.S. Jones trans., Loeb Classical Library 1923).

[4] See AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics: Current Opinions* ("*Code of Medical Ethics*") § 2.211, App. E.

initiatives concerning life sustaining technologies and end of life decisions,[5] the Medical Society of New Jersey has iterated the core of the profession's long standing opposition to the unlawful taking of human life: "Moreover, under physician assisted suicide, the medical profession's devotion to healing and refusal to kill, its ethical center, would be destroyed along with patient trust and physician self-constraint. Physicians do not require the tool of death."[6]

Throughout history it has been the physician's duty and responsibility to attend to the sick and dying. The members of the MSNJ hold that this sacred trust is best discharged by unwavering fidelity to ancient mileposts which respect that human life is sacred and that the healing arts adhere to the inviolable rule that doctors must not kill.[7]

The Medical Society of New Jersey submits that under these policies, the patient's role as the focal point of medical decision making is safeguarded and the integrity of the physician-patient relationship preserved by precluding the undermining acts which intentionally cause the death of the patient. The members of the Medical Society of New Jersey routinely rely upon these fundamental maxims when providing care to all patients.

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[5] *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976); *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985); *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *Matter of Peter by Johanning*, 108 N.J. 365, 529 A.2d 319 (1987); *Matter of Jobes*, 108 N.J. 394, 529 A.2d 434 (1987); N.J.S. 26:2H-53 to 78 and N.J.S. 52:27G-5.1 to 25.1.

[6] See Medical Society of New Jersey, *Statement on Physician Assisted Suicide*, 1 November 1996, App. A.

[7] Of an important ethical piece is the 12 September 1982 Medical Society of New Jersey *Policy Statement on Physician Administered Injections As a Means of Execution*, which holds that ". . . participation would undermine the moral and ethical foundations of medicine." App. B.

B. Decisions To Forego Life-Sustaining Treatment Are Profoundly Separate from Elections To Assist in Patient Self-Destruction

An individual's constitutional right to refuse life-prolonging medical treatment was first embraced by the New Jersey Supreme Court in its seminal decision concerning the plight of Karen Ann Quinlan, *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), and numerous state courts have affirmed the prerogatives reflected in the Medical Society of New Jersey's commitment to respect for patient decisions.[8]

Citing this Court and specific articles of the New Jersey constitution, the unanimous *Quinlan* court held: "We would see . . . a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support . . . in the face of irreversible, painful and certain imminent death." *Quinlan*, 70 N.J. at 43.[9]

Scholarly support for this crucial distinction is legion and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research underscored the critical variance: ". . . although declining to start or continue life-sustaining treatment is often acceptable, health care providers properly refuse to honor a patient's request to be directly killed. Not only would killing, as by violence or strychnine, be outside the bounds of accepted medical practice, but as murder it would be subject to a range

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[8] *See* National Center for State Courts, *Guidelines for State Court Decision Making in Authorizing or Withholding Life-Sustaining Medical Treatment* (1991), and Appendix A, the MSNJ's *Statement on Physician Assisted Suicide*.

[9] Since the *Quinlan* decision, state courts have uniformly embraced the significant moral and legal distinctions between letting die and killing (assisted suicide and euthanasia). *See also In re Conroy*, 98 N.J. at 350-351, National Center for State Courts, *Guidelines*, cited in f.n. 7, *supra*.

of criminal sanctions, regardless of the provider's motives." *Deciding to Forego Life Sustaining Treatment* (1983), at 63-64.

Widespread medical and public concern about drawing a line between a patient's right to choose medical treatment, on one side, and euthanasia or "mercy killing" and physician assistance in self-destruction, on the other led the Hastings Center to promulgate its report *Guidelines on the Termination of Life Sustaining Treatment and the Care of the Dying* (1987). While firmly endorsing the right of a competent patient, or surrogate for an incompetent patient, to forego life-sustaining medical treatments, the *Guidelines* roundly rejected euthanasia and assisted suicide:

> Medical tradition and customary practice distinguish in a broadly acceptable fashion between the refusal of medical interventions and intentionally causing death or assisting suicide. This tradition does not hold the health care professional morally responsible for the death of a patient when life-sustaining treatment is refused and the professional's purpose is not to cause death, but to honor the refusal. Similarly, the tradition defends the administration of a treatment that may hasten death when the professional's purpose is to relieve pain and suffering and the patient or surrogate consents. By contrast, this tradition does not permit administering massive doses of sedatives for the purpose of bringing about death, even if requested by the patient or surrogate.

Guidelines at 128.

The New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care and its sister commission, The New York State Task Force on Life and the Law, concluded that while competent adults have the fundamental right, in collaboration with their health care providers, to control decisions about their medical care, that prerogative is not absolute and is subject to certain interests of soci-

ety.[10] In its 1994 report, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context*, the New York Task Force unanimously recommended that:

> New York laws prohibiting assisted suicide and euthanasia should not be changed. In essence, we propose a clear line for public policies and medical practice between foregoing medical interventions and assistance to commit suicide or euthanasia. Decisions to forego treatment are an integral part of medical practice; the use of many treatments would be inconceivable without the ability to withhold or to stop the treatments in appropriate cases. We have identified the wishes and interests of patients as the primary guideposts for those decisions. Assisted suicide and euthanasia would carry us into new terrain - American society has never sanctioned assisted suicide or mercy killing. We believe that the practices would be profoundly dangerous for large segments of the population, especially in light of the widespread failure of American medicine to treat pain adequately or to diagnose and treat depression in many cases. The risks would extend to all individuals who are ill. They would be most severe for those whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, or membership in a stigmatized social group. The risks of legalizing assisted suicide and euthanasia for these individuals, in a health care system and society that cannot effectively protect against the impact of inadequate resources and ingrained social disadvantage, are likely to be extraordinary.

When Death Is Sought at vii-viii.

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10 New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care, *The New Jersey Advance Directives for Health Care and Declaration of Death Acts: Statutes, Commentaries and Analyses* (Princeton, 1991), App. F.

The policies and pronouncements of the Medical Society of New Jersey and the American Medical Association have helped to shape the broad legal and ethical consensus surrounding the recognition and vindication of patients' rights to forego life sustaining treatments[11] as well as prohibitions against assistance in their self destruction.[12]

Within the physician-patient relationship, physicians have a legal and ethical duty to the patient to ensure that treatment decisions are made which foster and protect the patient's best interests. *See* American Medical Association, *Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association*, Opinion 9.12 (1994). This duty extends to assisting our nation's highest tribunal as society wrestles with a critical case of first impression. The physician-patient relationship has historically played a central role in guarding the patient from treatment decisions which are inconsistent with sound medical practice and ethical conduct.

The members of the Medical Society of New Jersey submit that, by curing the failure of the Second Circuit's opinion to constitutionally recognize the critical variance between refusal of life-sustaining treatment and assistance in self-destruction, this Court will restore respect for patient sovereignty deeply rooted in accepted medical, ethical and legal principles.

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11 American Medical Association Opinion 2.20: *Withholding or Withdrawing Life-Sustaining Medical Treatment*, App. C.

12 Medical Society of New Jersey, *Statement on Physician Assisted Suicide*, App. A. American Medical Association Opinion 2.20; *Withholding or Withdrawing Life-Sustaining Medical Treatment*, App. C. American Medical Association Opinion 2.211; *Physician Assisted Suicide*, App. E. American Medical Association Opinion 2.21; *Euthanasia*, App. D.

II. STATES HAVE THE CONSTITUTIONAL COMPETENCE TO PROHIBIT ASSISTANCE IN SELF-DESTRUCTION

The Second Circuit's decision in *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), is based upon a flawed Fourteenth Amendment analysis, grounded upon an assertion there is no meaningful distinction between the refusal of medical procedures which might prolong life and the taking of affirmative steps which are sure to end it.[13] Relying upon case law holding that a competent patient has a right to forego or refuse life-sustaining medical treatment, the Second Circuit found a Fourteenth Amendment "liberty interest" which prevents a state from enacting laws against physicians assisting in the affirmative destruction of their patients. The Second Circuit held that such laws were not "rationally related" to any "legitimate governmental interest," and are therefore constitutionally infirm.

A fundamental fault in the Second Circuit's reasoning is the assumption that patient autonomy and the right to refuse life-sustaining treatment constitute a recognition of some constitutionally protected "right to die." The MSNJ and its physician members were in the forefront of the debate on these issues, participating in landmark cases before the Supreme Court of New Jersey which were the first in the nation to recognize and define the rights of patients near the end of life. The right of a competent patient to refuse treatment at life's end is simply an extension of the right to informed participation in treatment decisions during life, and is by no means a right to end life, no matter what the reasons.

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13 This assertion leads inexorably to an even more difficult question: if there is no such legally cognizable difference, then how can a distinction be drawn between the right of a terminally ill patient to destroy his own life via physician assisted suicide and the right of a patient who is severely debilitated or in intense, constant pain, but whose condition is not terminal, to similar "aid" in terminating his?

Past pronouncements of this Court as well recognize this crucial distinction.

As fully set forth in the first point of this brief, the medical profession has long-standing historical and ethical prohibitions against taking the lives of its patients. The states are constitutionally competent to rely upon these prohibitions to, in part, provide a rational basis to support statutes against assisted self-destruction.

A. New Jersey Has a Rich Juridical and Legislative Tradition Regarding Patient Autonomy in Treatment Decisions, Which Explicitly Rejects the Concept of Physician Assisted Self-Destruction

In *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976), the Supreme Court of New Jersey recognized that the state has an interest in "the preservation and sanctity of human life," 70 N.J. at 40, but that this interest had to be balanced against a patient's Fourteenth Amendment privacy right to refuse invasive medical procedures:

> We think that the State's interest [in preserving life] weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest. It is for that reason that we believe Karen's choice, if she were competent to make it, would be vindicated by the law. Her prognosis is extremely poor,—she will never resume cognitive life. And the bodily invasion is very great,—she requires 24 hour intensive nursing care, antibiotics, the assistance of a respirator, a catheter and a feeding tube.

Quinlan, 70 N.J. at 41.

With regard to physician assisted self-destruction, there is simply no right which may be balanced against the state's interest in "the preservation and sanctity of human life." A privacy interest in refusing medical intervention is in no way congruent with the liberty interest in suicide articulated by the Second Circuit. This was explicitly recognized by the *Quinlan* court:

> We would see, however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death.

Quinlan, 70 N.J. at 43. Under this rationale, a state certainly has a "rational basis" to draw a distinction between refusal of medical treatment and active self-destruction.[14]

The New Jersey Supreme Court again had occasion to consider the right to refuse medical intervention in *In re Conroy*, 98 N.J. 321, 486 A.2d 1209 (1985). The court did not articulate anything which could be construed as a "right to die." The case involved "the circumstances under which life-sustaining treatment may be withheld or withdrawn from incompetent, institutionalized, elderly patients with severe and permanent mental and physical impairments and a limited life expectancy." *Conroy*, 98 N.J. at 335.

Stating "[t]he starting point in analyzing whether life-sustaining treatment may be withheld or withdrawn from an incompetent patient is to determine what rights a competent patient has to accept or reject medical care," *Conroy*, 98 N.J. at 346, the court again balanced the state's interest in preserving life against the patient's right to make treatment decisions under the doctrine of informed consent. *See Conroy*, 98 N.J at 346-355.

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[14] In fact, after she was withdrawn from the respirator, Karen Ann Quinlan lived for a further nine years.

The court drew a clear distinction between refusing treatment and taking life:

> In any event, declining life-sustaining medical treatment may not properly be viewed as an attempt to commit suicide. Refusing medical intervention merely allows the disease to take its natural course; if death were eventually to occur, it would be the result, primarily, of the underlying disease, and not the result of a self-inflicted injury. [citations omitted] In addition, people who refuse life-sustaining medical treatment may not harbor a specific intent to die, [citation omitted]; rather, they may fervently wish to live, but to do so free of unwanted medical technology, surgery, or drugs, and without protracted suffering, [citation omitted].
>
> Recognizing the right of a terminally ill person to reject medical treatment respects that person's intent, not to die, but to suspend medical intervention at a point consonant with the "individual's view respecting a personally preferred manner of concluding life." [citation omitted] The difference is between self-infliction or self-destruction and self-determination.

Conroy, 98 N.J at 350-1.

In 1987, the New Jersey Supreme Court revisited these issues in a trilogy of cases: *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (1987); *Matter of Peter by Johanning*, 108 N.J. 365, 529 A.2d 319 (1987); and *Matter of Jobes*, 108 N.J. 394, 529 A.2d 434 (1987). These cases involved the circumstances under which life-sustaining medical treatment could be withheld or withdrawn. The court balanced the interests of the state in, *inter alia*, preserving life, against the patients' rights of self-determination and informed consent. Again, the court rejected any notion that the right to refuse treatment encompassed a right to commit suicide:

> Courts in other jurisdictions have consistently agreed that refusal of life-supporting treatment does not amount to an attempt to commit suicide. *See, e.g., Bartling v. Superior Court, supra*, 163 Cal. App.3d at 195-97, 209 Cal. Rptr. at 225-6; *Foody v. Manchester Memorial Hosp.*, 20 Conn. Supp. 127, ___, 482 A.2d 713, 720 (Super. Ct. 1984); *Satz v. Perlmutter, supra*, 362 So.2d at 162-63; *Brophy v. New England Sinai Hosp., supra*, 398 Mass. at 438, 497 N.E.2d at 638; *In re Eichner, supra*, 52 N.Y.2d at 377-78 n.6, 420 N.E.2d at 71 n. 6, 438 N.Y.S.2d at 273 n. 6; *Leach v. Akron General Medical Center*, 68 Ohio Misc. 1, 10, 426 N.E.2d 809, 815 (Ohio Com. Pl. 1980); *Colyer, supra*, 99 Wash.2d at 121, 660 P.2d at 743.

Farrell, 108 N.J. at 350.

The principles enunciated in these landmark cases are also reflected in New Jersey's statutes. Under New Jersey's Code of Criminal Justice:

> A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree.

N.J.S. 2C:11-6, App. G.

The *New Jersey Advance Directives for Health Care Act*, N.J.S. 26:2H-53, *et seq.*, essentially codifies the holdings in the above-discussed cases, and provides for a legally enforceable procedure for embodying an individual's advance treatment decisions in writing. The statute contains the following legislative finding:

> The right of individuals to forego life-sustaining measures is not absolute and is subject to certain interests of society. The most significant of these societal interests is the preservation of life, understood to embrace both an interest in preserving the life of the particular patient and

> a related but distinct interest in preserving the sanctity of all human life as an enduring social value. A second, closely related societal interest is the protection of individuals from direct and purposeful self-destruction, motivated by a specific intent to die.

N.J.S. 26:2H-54(d), App. F.

These cases and statutes constitute a well-established and cohesive body of law, which has evolved in harmony with the ethical tenets of the medical profession. The Second Circuit's decision both ignores and contradicts this tradition.

B. Past Pronouncements of This Court Inform and Authenticate Prohibitions Against Assistance in Self-Destruction

This Court has had occasion to consider the issues raised by the above-cited New Jersey Supreme Court cases. In *Cruzan v. Director, Missouri Health Dept.*, 497 U.S. 261 (1990), this Court upheld a Missouri statute requiring proof by clear and convincing evidence of an incompetent patient's wishes to withdraw life-sustaining medical treatment against a due process challenge. As did the New Jersey Supreme Court, this Court recognized a clear distinction between the withholding or withdrawal of medical treatment on the one hand, and the purposeful destruction of life on the other.

This Tribunal balanced Missouri's interest in the preservation of life against the patient's Fourteenth Amendment liberty interest in refusing unwanted medical treatment. It held that the state's interest in requiring proof of intention to forego life-sustaining medical treatment by a heightened evidentiary standard outweighed a patient's right to forego treatment. In so holding, the Court stated:

> Finally, we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified

> interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

Cruzan, 497 U.S. at 282.

Under the *Cruzan* decision, states have a clear and compelling interest in the preservation of life, to the extent they may require procedural safeguards which could conceivably infringe upon a patient's Fourteenth Amendment liberty interest in refusing unwanted medical treatment. It follows, without question, that the states have an even more compelling interest in enacting statutes against assistance in self-destruction; no pronouncement of this Court even hints that an individual has any constitutional right to commit suicide which might be balanced against this compelling state interest.

This "right to suicide" found by the Second Circuit has no foundation in statute or the common law. It may not be created by analogy to the right to refuse medical treatment. There is therefore nothing to "balance" in the context of a Fourteenth Amendment analysis. Indeed, in addition to New Jersey, thirty-nine other states, Puerto Rico and the U.S. Virgin Islands have statutes or common-law prohibitions against assisting suicide, or have statutes criminalizing negligent homicide which are broad enough to encompass assisted suicide.[15] The MSNJ submits that these court decisions and legislative pronouncements evince a strong interest on the part

[15] *See* Ala. Code, § 13A-6-1; Alaska Stat., § 11.41.120(a)(2); Ariz. Rev. Stat. Ann., § 13-1103(A)(3); Ark. Stat. Ann., § 5-10-104(a)(2); Cal. Pen. Code, § 401; Colo. Rev. Stat., § 18-3-104(1)(b); Conn. Gen. Stat., § 53a-56(a)(2); Del. Code Ann., tit. 11, § 645; Fla. Stat. Ann., § 782.08; Ga. Code Ann., § 16-5-5(b); Ill. Comp. Stat. ch. 720, 5/12-31; Ind. Stat. Ann., § 35-42-1-2.5(b); Ia. Code, §§ 707A.1, 707A.2 and 707A.3, as amended by Acts of the 76th General Assembly, 1996 Session; Kan. Stat. Ann. § 21-3406; Ky. Rev. Stat., § 216:302; La. Rev. Stat., § 14:32.12; Me. Rev. Stat. Ann., tit. 17-A, § 204; *Commonwealth v. Mink*, 123 Mass. 422, 428-29 (Mass. 1877); *People v. Kevorkian*, 447 Mich. 436, 527 N.W.2d 714 (Mich. 1994); Minn. Stat. Ann., § 609.215; Miss. Code Ann., § 97-3-49; Mo. Ann. Stat., § 565.023(1)(2); Mont. Code Ann., § 45-5-105; Neb. Rev. Stat., § 28-307; N.H. Rev. Stat. Ann., § 630:4; N.M. Stat. Ann., § 30-2-4; N.Y. Penal Law, §§ 120.30, 125.15(3); *State v. Willis*, 121 S.E.2d 854 (N.C. 1961); N.D. Cent. Code., § 12.1-16-04; *Blackburn v. State*, 23 Ohio St. 146, 163 (Ohio 1972); Okla. Stat. Ann., tit. 21, §§ 813-818; 18 Pa. Cons. Stat. Ann., § 2502; P.R. Laws Ann., tit. 33, § 4009; *State v. Jones*, 86 S.C. 17, 67 S.E. 160, 165 (S.C. 1910); S.D. Codified Laws Ann., § 22-16-37; Tenn. Code Ann., § 39-13-216; Tex. Penal Code Ann., § 22.08; V.I. Code Ann., tit. 14, § 2141; Wash. Rev. Code Ann., § 9A.36.060; Wis. Stat. Ann., § 940.12; and Wyo. Stat., § 6-2-107.

of New Jersey, other states, commonwealths and territories, in the preservation of life. This interest is bolstered by long-standing ethical precepts of the medical profession prohibiting the wilful destruction of the life of a patient. Laws prohibiting assisted suicide are rationally related to this state interest.

CONCLUSION

Accordingly, the Medical Society of New Jersey, as Friend of the Court, respectfully urges this Court, for all the foregoing reasons, and for those stated in the briefs for the petitioners and other supporting *amici*, to reverse the decision below.

Respectfully submitted,

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12 November 1996

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APPENDIX

APPENDIX A

MEDICAL SOCIETY OF NEW JERSEY STATEMENT ON PHYSICIAN ASSISTED SUICIDE

Physicians cannot serve the patient's good by deliberately eliminating the patient. There has been, is and always will be a clear distinction between causing a death as contrasted with permitting death to occur.

"Aid-in-dying," the right to die, physician-assisted suicide or euthanasia imply an obligation on the part of others to kill or help kill. There is no such right. It is difficult to imagine and configure a limited statute permitting homicide by a privileged few and exercised in the name of humanity.

Further, there is no way to confine the practice to those knowingly and really requesting death. The vast majority of persons who are candidates for assisted death are, and increasingly will be, incapable of choosing and effecting such a course of action for themselves. No one with an expensive or troublesome infirmity will be safe from the pressure to have his right to die exercised. Some reasons in favor of death might even be construed as a duty to die.

Moreover, under physician-assisted suicide, the medical profession's devotion to healing and refusal to kill, its ethical center, would be destroyed along with patient trust and physician self-constraint. Physicians do not require the tool of death.

Sentiments in support of physician-assisted suicide are understandable in a culture which at times is tempted to embrace seemingly easy solutions to complex social and moral issues. Support for physician-assisted suicide may also be fueled by a limitless sense of individual rights and personal autonomy. Popular support for physician-assisted suicide may also be the consequence of the legitimate concerns of individuals who fear that confronting death at the end of a terminal illness may result in a loss of their dignity, unrelieved pain and even abandonment by their physicians.

In the face of recent and pending court decisions, and despite popular sentiments in American culture, the Medical Society of New Jersey affirms without equivocation its opposition to euthanasia and physician-assisted suicide in any form or manner. Furthermore, the Medical Society of New Jersey endorses the official policy of the American Medical Association (Policy 140.952) which declares that "physician assisted suicide is fundamentally inconsistent with the physician's professional role." The Medical Society also endorses the Opinion of the Council on Ethical and Judicial Affairs (Opinion 2.211) which states that "physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks."

Although the Medical Society of New Jersey stands in opposition to physician-assisted suicide, this position should not be interpreted in any way so as to compromise the ethically and legally protected right of terminally ill patients to participate fully in treatment decisions at the end of life, including the right to execute and implement advance directives and to refuse or request the withdrawal of aggressive forms of medical treatment which in the informed opinion of the patient impose burdens which outweigh the benefits.

Nor should the Medical Society's opposition to all forms of physician-assisted suicide be interpreted to compromise the right of patients to receive appropriate pain treatment to relieve suffering in the final stages of a terminal illness. The provision of appropriate pain treatment, even if in some instances this may hasten the death of the patient, does not constitute a form of physician-assisted suicide. The Medical Society of New Jersey, echoing the ethical principles espoused by the American Medical Association, recognizes a fundamental ethical distinction between actions which are directly intended to end the life of a patient and actions which have, as a secondary consequence, this effect.

Finally, we are eager that physicians throughout the state vigorously discuss responsibilities to dying patients with each

other, with other professionals, and with patients. This conversation will serve to enhance our ethics and our care.

1 November 1996

APPENDIX B

MEDICAL SOCIETY OF NEW JERSEY POLICY STATEMENT ON PHYSICIAN ADMINISTERED INJECTIONS AS A MEANS OF EXECUTION

American physicians, from the beginnings of this republic, have participated freely and enthusiastically in the wars this nation has endured, exercising, as required, their healing skills on both friend and foe. They have never been asked to take life during these conflicts, nor has it been deemed proper to ask this of them, recognizing that one of the enduring and basic ethical principles of the physician has been to conserve and preserve life in a cognitive, sapient, and vital human being.

The recent enactment of a death penalty statute in New Jersey and the suggestion that execution be by injection have, of necessity, caused the Medical Society of New Jersey to re-examine these principles. Agreement or disagreement with imposition of a death penalty and agreement or disagreement with the method of execution and its "humane" qualities are not germane to the central issue, i.e., whether a physician may ethically take human life by active participation in a legally ordered execution.

We think not, feeling that acceptance of such participation would undermine the moral and ethical foundations of medicine.

Accordingly, the Board of Trustees of the Medical Society of New Jersey reaffirms the ethical necessity for the physician to practice only the positive aspects of the healing arts and to respect the sanctity of human life, and further reaffirms the policy statement of the American Medical Association, which states that a "physician, as a member of a profession dedicated to preserving life when these is hope of doing so, should not be a participant in a legally authorized execution."

The role of a physician in pronouncing or determining the cause of death after an execution would not be affected and would continue to be acceptable.

Adopted by the Board of Trustees September 12, 1982.

APPENDIX C

AMERICAN MEDICAL ASSOCIATION OPINION 2.20: WITHHOLDING OR WITHDRAWING LIFE-SUSTAINING MEDICAL TREATMENT

The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the preferences of the patient should prevail. The principle of patient autonomy requires that physicians respect the decision to forego life-sustaining treatment of a patient who possesses decisionmaking capacity. Life-sustaining treatment is any treatment that serves to prolong life without reversing the underlying medical condition. Life-sustaining treatment may include, but is not limited to, mechanical ventilation, renal dialysis, chemotherapy, antibiotics, and artificial nutrition and hydration.

There is no ethical distinction between withdrawing and withholding life-sustaining treatment.

A competent, adult patient may, in advance, formulate and provide a valid consent to the withholding or withdrawal of life-support systems in the event that injury or illness renders that individual incompetent to make such a decision.

If the patient receiving life-sustaining treatment is incompetent, a surrogate decisionmaker should be identified. Without an advance directive that designates a proxy, the patient's family should become the surrogate decisionmaker. Family includes persons with whom the patient is closely associated. In the case when there is no person closely associated with the patient, but there are persons who both care about the patient and have sufficient relevant knowledge of the patient, such persons may be appropriate surrogates. Physicians should provide all relevant medical information and explain to surrogate decisionmakers that decisions regarding withholding or withdrawing life-sustaining treatment should be based on substituted judgment (what the patient would have decided) when there is evidence of the patient's preferences

and values. In making a substituted judgment, decisionmakers may consider the patient's advance directive (if any); the patient's values about life and the way it should be lived; and the patient's attitudes towards sickness, suffering, medical procedures, and death. If there is not adequate evidence of the incompetent patient's preferences and values, the decision should be based on the best interests of the patient (what outcome would most likely promote the patient's well-being).

Though the surrogate's decision for the incompetent patient should almost always be accepted by the physician, there are four situations that may require either institutional or judicial review and/or intervention in the decisionmaking process: (1) there is no available family member willing to be the patient's surrogate decisionmaker, (2) there is a dispute among family members and there is no decisionmaker designated in an advance directive, (3) a health care provider believes that the family's decision is clearly not what the patient would have decided if competent, and (4) a health care provider believes that the decision is not a decision that could reasonably be judged to be in the patient's best interests. When there are disputes among family members or between family and health care providers, the use of ethics committees specifically designed to facilitate sound decisionmaking is recommended before resorting to the courts.

When a permanently unconscious patient was never competent or had not left any evidence of previous preferences or values, since there is no objective way to ascertain the best interests of the patient, the surrogate's decision should not be challenged as long as the decision is based on the decisionmaker's true concern for what would be best for the patient.

Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death.

Even if the patient is not terminally ill or permanently unconscious, it is not unethical to discontinue all means of

life-sustaining medical treatment in accordance with a proper substituted judgment or best interests analysis. (I,III,IV,V)

Issued March 1981 (Opinion 2.11: Terminal Illness) and December 1984 (Opinion 2.19: Withholding or Withdrawing Life-Prolonging Medical Treatment: Patient's Preferences, renumbered as Opinion 2.21 in August 1989).

APPENDIX D

AMERICAN MEDICAL ASSOCIATION OPINION 2.21: EUTHANASIA

Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Issued June 1994 based on the report "Decisions Near the End of Life," issued June 1991. (JAMA, 1992;267:2229-2233)

APPENDIX E

AMERICAN MEDICAL ASSOCIATION OPINION 2.211: PHYSICIAN ASSISTED SUICIDE

Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication.

Issued June 1994 based on the reports "Decisions Near the End of Life," issued June 1991, and "Physician-Assisted Suicide," issued December 1993. (JAMA. 1992; 267: 2229-2233)

APPENDIX F

NEW JERSEY COMMISSION ON LEGAL ETHICAL PROBLEMS IN THE DELIVERY OF HEALTH CARE, *THE NEW JERSEY ADVANCE DIRECTIVES FOR HEALTH CARE AND DECLARATION OF DEATH ACTS: STATUTES, COMMENTARIES AND ANALYSES* (1991)

AN ACT concerning health care decisionmaking and supplementing Title 26 and Title 52 of the Revised Statutes.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

Section 1: Short Title

This act shall be known and may be cited as the "New Jersey Advance Directives for Health Care Act."

Section 2: Legislative Findings

The Legislature finds and declares that:

a. Competent adults have the fundamental right, in collaboration with their health care providers, to control decisions about their own health care. This State recognizes, in its law and public policy, the personal right of the individual patient to make voluntary, informed choices to accept, to reject, or to choose among alternative courses of medical and surgical treatment.

b. Modern advances in science and medicine have made possible the prolongation of the lives of many seriously ill individuals, without always offering realistic prospects for improvement or cure. For some individuals the possibility of extended life is experienced as meaningful and of benefit. For others, artificial prolongation of life may seem to provide nothing medically necessary or beneficial, serving only to extend suffering and prolong the dying process. This State recognizes the inherent dignity and value of human life and

within this context recognizes the fundamental right of individuals to make health care decisions to have life-prolonging medical or surgical means or procedures provided, withheld, or withdrawn.

c. In order that the right to control decisions about one's own health care should not be lost in the event a patient loses decisionmaking capacity and is no longer able to participate actively in making his own health care decisions, this State recognizes the right of competent adults to plan ahead for health care decisions through the execution of advance directives, such as living wills and durable powers of attorney, and to have the wishes expressed therein respected, subject to certain limitations.

d. The right of individuals to forego life-sustaining measures is not absolute and is subject to certain interests of society. The most significant of these societal interests is the preservation of life, understood to embrace both an interest in preserving the life of the particular patient and a related but distinct interest in preserving the sanctity of all human life as an enduring social value. A second, closely related societal interest is the protection of individuals from direct and purposeful self-destruction, motivated by a specific intent to die. A third interest is the protecting of innocent third parties who may be harmed by the patient's decision to forego therapy; this interest may be asserted to prevent the emotional and financial abandonment of the patient's minor children or to protect the paramount concerns of public health or safety. A fourth interest encompasses safeguarding the ethical integrity of the health care professions, individual professionals, and health care institutions, and maintaining public confidence and trust in the integrity and caring role of health care professionals and institutions. Finally, society has an interest in ensuring the soundness of health care decisionmaking, including both protecting vulnerable patients from potential abuse or neglect and facilitating the exercise of informed and voluntary patient choice.

e. In accordance with these State interests, this State expressly rejects on both legal and moral grounds the practice of active euthanasia. No individual shall have the right to, nor shall any physician or other health care professional be authorized to engage in, the practice of active euthanasia.

f. In order to assure respect for patients' previously expressed wishes when the capacity to participate actively in decisionmaking has been lost or impaired; to facilitate and encourage a sound decisionmaking process in which patients, health care representatives, families, physicians, and other health care professionals are active participants; to properly consider patients' interests both in self-determination and in well-being; and to provide necessary and appropriate safeguards concerning the termination of life-sustaining treatment for incompetent patients as the law and public policy of this State, the Legislature hereby enacts the New Jersey Advance Directives for Health Care Act.

APPENDIX G

NEW JERSEY CODE OF CRIMINAL JUSTICE—HOMICIDE

Aiding suicide

A person who purposely aids another to commit suicide is guilty of a crime of the second degree if his conduct causes such suicide or an attempted suicide, and otherwise of a crime of the fourth degree. L.1978, c.95 § 2C:11-6, eff. Sept. 1, 1979.

(37) (39)

Supreme Court, U.S.
FILED
NOV 12 1996
CLERK

Nos. 96-110 and 95-185

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, *Petitioners*,

v.

HAROLD GLUCKSBERG, *et al.*, *Respondents*.

DENNIS C. VACCO, Attorney General of New York, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, *et al.*, *Respondents*.

On Writs of Certiorari
to the United States Courts of Appeals
for the Ninth and Second Circuits

BRIEF OF FAMILY RESEARCH COUNCIL AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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30 pp

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
INTEREST OF THE *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	2
ARGUMENT	4
I. THE HISTORY OF "EUTHANASIA" IN NAZI GERMANY IS RELEVANT TO THE ISSUE OF WHETHER ASSISTED SUICIDE SHOULD BE RECOGNIZED AS A CONSTITUTIONAL RIGHT	4
II. THE GERMAN "EUTHANASIA" PROGRAM WAS CARRIED OUT BY A MEDICAL PROFESSION THAT VIEWED KILLING OF INCURABLE AND "MENTALLY DEFECTIVE" PATIENTS AS A HEALING ACT	7
A. Euthanasia in Germany Began with Proposals for Medical Killing, Under Strict Guidelines, of Defined Classes of Incurable Patients	8
1. Hoche and Binding	8
2. Response of the German Medical Community and Impact of the Rise of Nazism	11
3. Cultural Responses	13

B. Direct Medical Killing Began With Permision for Physician-Assisted Death In the Cases of Incurable Infants and Adults and Rapidly Expanded to Other Catagories of Patients..... 15

1. Merciful Deaths for Children..... 16

2. T-4 Program: Euthanizing of Terminally Ill, Disabled, and Mentally Incompetent German Patients..... 18

3. Genocide Under 14f13: "Special Treatment" for Jews and Other "Undesirables"..... 23

III. TESTIMONY FROM THE TRIALS OF MEDICAL KILLINGS IN GERMANY PROVES THE NECESSITY OF AN ABSOLUTE PROHIBITION AGAINST KILLING BY PHYSICIANS..... 24

CONCLUSION..... 29

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INTEREST OF *AMICUS CURIAE*[*]

Family Research Council, Inc., is a non-profit research and educational organization dedicated to the preservation and defense of traditional values and the family. The Family Research Council believes in the incomparable value of every human person, regardless of age or infirmity. Among the chief guardians of this principle in any society is a medical profession dedicated above all else to the preservation of human life and the equal dignity of all persons. In the opinions below, the Second Circuit and Ninth Circuit have struck a blow against the foundational ethic of medicine: that doctors must not kill. In so doing, both courts advance the unsupported contention that allowing a small measure of physician-assisted killing will advance the dignity of the dying process and have no adverse effects on the ethics of the medical profession or its dedication to preserve human life.

Other *amici*, chiefly the American Medical Association, the American Psychiatric Association, and the American Suicide Foundation, address why this contention is false in light of the contemporary medical environment. In this brief, Family Research Council invites the Court to consider the relevance of history's most tragic experience of physician-assisted death: the German euthanasia program of the 1930s and 1940s. This experience demonstrates the risks of corruption of the medical profession in particular and civil society at large inherent in implementing physician-assisted killing. Failure to heed the lessons of history's most calamitous experience in this area would be tragic. For the sake of American families and the integrity of this nation, this is a risk that should not be imposed in the guise of a newly-found right under either the Equal Protection or Due Process clauses of the Fourteenth Amendment.

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[*] This brief is submitted with the written consent of all parties, filed with the clerk of this Court.

SUMMARY OF ARGUMENT

Under Germany's "euthanasia" program of the 1930s and 1940s, the lives of hundreds of thousands of terminally ill, incurably sick, and mentally incompetent patients were terminated by physicians who accepted the notion that there are lives not worthy to be lived. While the lessons to be learned from this chapter of history will never be free from controversy, certain facts are both indisputable and highly relevant to the question of whether any nation should enshrine a right to physician-assisted killing in its fundamental charter of rights.

First, the erosion in medical ethics that made possible the participation of German physicians and health care workers in the widespread killing of asylum patients and other "incurables" was not of Nazi, fascist, or even peculiarly German origin. The prospect of killing the chronically sick and disabled was widely discussed in Germany, and elsewhere, long before the rise of the Third Reich.

> There was nothing creative or innovative about Nazi social policy in this regard. The Nazis were consistent and effective in the implementation, but responsibility for the origins of their policies rested with others—the medical profession, the scientific community, and the intelligentsia generally.

Hugh Gregory Gallagher, By Trust Betrayed: Patients, Physicians, and the License to Kill in the Third Reich 95 (1990).

Second, those guilty of crimes relating to euthanasia defended their actions at the time, at their trials, and, in the case of those who escaped serious punishment, in later years, by citing the compassionate and humanitarian motive of ending lives classified as *lebensunwerten Leben.* While the Nazi dictatorship (and, eventually, the War) provided the

conditions necessary for such killings to be carried out on a wide scale, the concept of "life unworthy to be lived" made doctors voluntary and willing participants in these events.

Third, those involved in the investigation and prosecution of these crimes confirmed their "small beginnings," and warned against the consequences of accepting similar notions in other societies.[1] Euthanasia's "small beginnings" so thoroughly corrupted German medicine that it could not resist becoming a key component of the Nazi killing machine. It is imprudent at best to presume that such "small beginnings" would not have a corrosive effect on the medical profession in this nation.

For many reasons, physician-assisted death as a purported "cure" for human suffering would be "a medical, moral, and social disaster." Daniel Callahan and Margot White, *The Legalization of Physician-Assisted Suicide: Creating a Regulatory Potemkin Village*, 30 Rich. L. Rev. 1, 4 (1996). Alleviating the suffering of the afflicted by the infliction of

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[1] In the foreword to his book, *Die Unfähigkeit zu trauern* (1977) (The Inability to Mourn), Dr. Alexander Mitscherlich, a German psychiatrist who attended the "Medical Case" Nuremberg trial, *United States v. Karl Brandt, et al.*, and prepared an abstract of the evidence and proceedings for the West German Physicians' Chambers, warned that

> Today in many minds, there is a reluctance to accept the facts of history. This inclination or attitude is in some way similar to the fantasies which permeated the Third Reich. What happened in the years of the Third Reich remains alive in our subconscious, dangerously so. It will be fatal for us to lose touch with the truth of what happened then. We must struggle to seek out the truth of that era, rather than search for improved defenses to hide us from this truth.

Quoted in Gallagher, *By Trust Betrayed, supra* at 274.

death is a practice wholly unworthy of protection by the Constitution of the United States.

ARGUMENT

I. THE HISTORY OF "EUTHANASIA" IN NAZI GERMANY IS RELEVANT TO THE ISSUE OF WHETHER ASSISTED SUICIDE SHOULD BE RECOGNIZED AS A CONSTITUTIONAL RIGHT.

The prohibition against physicians participating in causing the death of their patients is ancient in origin and universal in scope. Even in the Netherlands, the only nation in the world to tolerate euthanasia on a large scale, the criminal prohibitions against the practice have not been repealed. Only two jurisdictions—the Northern Territory of Australia and the State of Oregon—have formally decriminalized assisted suicide. Otherwise, the laws of every nation reflect the attitude of anthropologist Margaret Mead when she described the Hippocratic Oath's proscription on physicians killing their patients as a benchmark of our civilization:

> [T]his is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer -- to kill the defective child at birth, to leave the sleeping pills beside the bed of the cancer patient. . . . [I]t is the duty of society to protect the physician from such requests.

Margaret Mead, Personal Correspondence, *quoted in* Maurice Levine, *Psychiatry and Ethics* 324-25 (1972).

This century has witnessed both the propagation and abhorrent consequences of an opposing ideal: the notion that, due to infirmity, suffering, or lack of consciousness, there is such a thing as a life not worthy to be lived, and hence a

responsibility on the part of the law to permit physicians to end such lives in a humanitarian manner.

Movements to legalize euthanasia are more than a century old. In the early part of this century, particularly in the years between World War I and World War II, the issue gained notoriety and support in several nations. American legal scholars such as Herbert Wechsler and Jerome Michael supported the legalization of voluntary euthanasia, and a bill to this effect was debated in the House of Lords in 1936. Yale Kamisar, *Some Non-Religious Views Against Proposed "Mercy Killing" Legislation*, 42 Minn. L. Rev. 969, 970, 1014-1018 (1958); Robert Proctor, *Racial Hygiene: Medicine Under the Nazis* 177 (1988). Public opinion was divided, Kamisar, *supra* at 1029, while elite figures such as certain Nobel Prize winners and professors at Harvard, Cornell, and elsewhere argued for "the privilege of death" for those "who wish to die." Proctor, *Racial Hygiene*, *supra* at 180.

Euthanasia also was advocated in Germany. As early as 1895, a widely-used German medical textbook made a claim for "the right to death." Michael Berenbaum, *The World Must Know: The History of the Holocaust as Told in the United States Holocaust Memorial Museum* 64 (1993). Immediately following World War I, the notion took greater root in the German medical and legal professions, instigated largely by publication by Professors Karl Binding and Alfred Hoche of *Die Freigabe der Vernichtung lebensunwertens Leben* (Permitting the Destruction of Unworthy Life) (1920). *See* 8 Issues in Law & Med. 221 (1992) (Patrick Derr and Walter Wright, trans.) (copies of which have been lodged with the Court).

What transpired in Germany in the late 1930s and 1940s would unalterably change the debate over the ethics and legality of physicians participating in ending the lives of their

patients. In that period, the lives of hundreds of thousands of terminally ill, incurably sick, and mentally incompetent patients were terminated by German doctors—the elite of the profession in Europe—in a program of "euthanasia" propagated both by acceptance of the "unworthy life" thesis and by the imposition of National Socialist theories of eugenics derived from earlier concepts developed by the German medical profession and intelligentsia. Michael Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-1945* 93-97, 273-277, 284-285 (1994); Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* 44-79 (1986); Gallagher, *By Trust Betrayed, supra* at 74-95.

In the ensuing decades, the connection of medical killing in Nazi Germany to contemporary debates regarding the legalization of assisted suicide and euthanasia has been a matter of great controversy. Burleigh, *Death and Deliverance, supra* at 291-298.[2] It is clear, however, that those closest to these events saw some connection. The condemnation of the "Nazi doctors" was universal and prompted great reflection on the question of ensuring that their actions never be repeated. As one step, the world's physicians reaffirmed the foundational ethical principle of their profession: that doctors must not kill.[3] The cases before this Court are the most important juridical test since that time of the meaning of that principle. For this reason alone, the experience which influenced so much of what

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[2] *See also* Nat Hentoff, *et al.*, *Contested Terrain: The Nazi Analogy in Bioethics*, Hastings Center Rep., Aug.-Sept. 1988 at 29.

[3] The *Declaration of Geneva*, adopted by the General Assembly of the World Medical Association in September 1948, re-affirmed the key precepts of the Hippocratic tradition: "I will maintain the utmost respect of human life from the time of conception, even under threat, I will not use my medical knowledge contrary to the laws of humanity." *See* Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 331 (2d ed. 1983).

the world thinks today of the issue of euthanasia is relevant to the deliberations of this Court.

The acceptance by physicians of the notion of a "life not worthy to be lived" under the "euthanasia" program was a cornerstone of the horror that was to follow. Leo Alexander, *Medical Science Under Dictatorship*, 241 New Eng. J. Med. 39, 44 (1949). Without the willingness of doctors to participate, the euthanasia program would not have occurred. Patrick Derr, *Hadamar, Hippocrates, and the Future of Medicine: Reflections on Euthanasia and the History of German Medicine*, 4 Issues in Law & Med. 487 (1989). This "cornerstone" principle persists today. The experience of the Netherlands (described in the Brief of *Amicus Curiae* the American Suicide Foundation in No. 96-110) establishes that the participation of physicians in killing their patients invariably rests upon, and propagates, the notion of life unworthy of life. The writings of pro-euthanasia philosophers James Rachels, Peter Singer, and John Harris[4] confirm this fact. While social and political conditions in Western democracies obviously differ from those of post-World War I and Nazi Germany, the consequences of legalizing physician-assisted suicide and euthanasia will be no less dire.

II. THE GERMAN "EUTHANASIA" PROGRAM WAS CARRIED OUT BY A MEDICAL PROFESSION THAT VIEWED KILLING INCURABLE AND "MENTALLY DEFECTIVE" PATIENTS AS A HEALING ACT.

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[4] *See* James Rachels, *The End of Life* 77 (1986) (acknowledging that euthanasia is less about autonomny than about societal recognittion that certain human beings lack suffient human attributes to possess a "life"); Peter Singer, *Bioethics and Academic Freedom*, Bioethics (1990); John Harris, *Euthanasia and the Value of Life*, Euthanasia Examined: Ethical, Clinical and Legal Perspectives 6 (J. Keown ed. 1995).

A. Euthanasia in Germany Began with Proposals for Medical Killing, Under Strict Guidelines, of Defined Classes of Incurable Patients.

In interbellum Germany, the medical and legal professions were influenced by proposals that patients in certain categories would benefit from hastened death. In so doing, "the most humane, the most sophisticated, the most scientifically advanced medical community [in] the world" between 1920 and 1940 self-destructed formulating and promoting ideas of physician-assisted death. Derr, *supra*, 8 Issues in Law & Med. at 488. *See also* Proctor, *Racial Hygiene, supra* at 282-83; Lifton, *The Nazi Doctors, supra* at 45-51; Burleigh, *Death and Deliverance, supra* at 11-20. *Sterbehilfe*, "dying help," was advocated by the elite medical profession for the incurably sick and was considered to be *Wohltat*, a merciful act. Proctor, *Racial Hygiene, supra* at 178-79.

1. Hoche and Binding.

The Binding and Hoche work, *Permitting the Destruction of Unworthy Life*, advocated *Sterbehilfe* as a compassionate and humanitarian response for those who requested it, pursuant to a carefully controlled process. The text was "crucial" and "most important" in creating acceptance within the profession for direct medical killing, and for active participation in the euthanasia program that was to be instituted. Wertham, *The Geranium in the Window*, (1966), *reprinted in* Death, Dying & Euthanasia at 610-611(D. Horan & D. Mall, eds 1980); Lifton, *The Nazi Doctors, supra* at 45-58.

Prof. Binding was one of Germany's leading specialists in constitutional and criminal jurisprudence. Dr. Hoche was a psychiatrist. The jurist Binding queried: "Should permissible taking of life be restricted . . . to an individual's act of suicide as it is in current law, or should it be legally extended to the

killing of fellow human beings, and under what conditions?" 8 Issues in Law & Med. at 232. He answered affirmatively for three groups of persons: (1) "those irretrievably lost as a result of illness or injury, who, fully understanding their situation, posses and have somehow expressed their urgent wish for release"; (2) "incurable idiots" from whom "there is no valid consent to be killed" but whose lives are "completely without purpose" and "a fearfully heavy burden both for their families and for society"; and (3) formerly competent patients who, due to trauma, "have become unconscious and who, if they should ever again rouse form their comatose state, would waken to nameless suffering." *Id.* at 247-49.[5]

Hoche asked a somewhat different question, also answered affirmatively: "Is there human life which has so completely lost the attribute of legal value that its continuation has permanently lost all value both for the bearer of that life and for society?" *Id.* at 258. Hoche appeared to warn against a purely utilitarian approach:

> In the times of need which we now face, we will never stop caring for the physically defective or ill, so long as they are not mentally dead. We will never cease giving the best possible care to the physically and mental ill, so long as there is any prospect of improvement in their condition.

Id. at 262.[6]

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[5] As to this last group, Binding expressed doubt that "a standard procedure can be created for managing this groups of killings. Cases will occur in which killing seems actually fully justified; but it can also happen that the agent, in the belief that he acted correctly, acted precipitously." *Id.* at 250.

[6] What did Hoche mean by the "mentally dead"? He explained this condition in two ways. With respect to "external relationships," the mentally dead individual "lacks any productive accomplishments and lives in a condition of total helplessness, requiring care by another." *Id.* With respect to his "inner state," clear ideas, feelings, or acts of will cannot arise . . . no emotional links to the environment can arise (even though they may naturally be the object of the inclinations of someone else)." *Id.*

Binding and Hoche explicitly condemned mercy-killings which took place contrary to the will of the victim, and emphasized the consent of the victim as a necessary condition for the killing of incurably ill people.[7] With regard to his first defined category, Binding stressed that the only people who may be candidates for having their deaths permitted are those who are terminally ill and who "have either requested death or consented to dying." 8 Issues in Law & Med. at 262.[8] Consent was of crucial importance to Binding: "*every permitting of killing which requires violating the will to live of the actual or potential victim is ruled out.*" *Id.* (emphasis in original).

Hoche and Binding advocated providing *Sterbehilfe* in a carefully controlled process, with evaluation by a three-person panel of professionals and the ability of the person to withdraw consent at any time. *Id.* at 252. They recommended that the initiative be made by the patient in the form of an "application for permission." *Id.* The application would go to a government board composed of a physician, a psychiatrist, and a lawyer,

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[7] In general, euthanasia as described by Binding and Hoche and their German predecessors had a societal and statist component that distinguished it from the American tradition of individual rights, to which the current euthanasia movement adheres. *See* Lifton, *The Nazi Doctors, supra* at 47. The distinction, however, may be more sharp in theory than in practice. Contemporary euthanasia proponents do not rely exclusively on the autonomy of those whose lives would be ended, but on the notion that such persons have ceased to have a "life." *See* Rachels, Singer, and Harris, *supra* note 4. In the Netherlands, moreover, most physician-assisted deaths occur without the explicit request of the patient. *See* Brief *Amicus Curiae* of the American Suicide Foundation in No. 96-110.

[8] As for the third category, Binding considered as proper candidates those who "would (had they not fallen into unconsciousness at the critical time or if they had been able to achieve awareness of the situation) have requested or consented." 8 Issues in Law & Med. at 250.

and unanimity would be required in granting permission. *Id.* The decree of permission would indicate that a "thorough investigation" had been undertaken, that the patient "seems beyond help," and that "there is no reason to doubt the sincerity of his consent." *Id.*

Yet, Binding conceded that this orderly procedure would not always be followed: "Perhaps following it is not even thinkable. Perhaps following the procedure, even expeditiously, would entail unbearable suffering for the patient." *Id.* at 253. Binding considered the possibility that doctors would be faced with the choice of "consign[ing]" the patient to continued suffering and the family and physician "to complete passivity" during the application process, or allowing the "accomplices" to satisfy their "consciences" that the required conditions were present for permissible killing. He favored the latter: "Without hesitation, I endorse the second alternative." *Id.* The second alternative would result in punishment of the accomplice in the case of "unpardonable" error. *Id.*[9]

2. Response of the German Medical Community and the Impact of the Rise of Nazism.

The Hoche and Binding monograph was much debated by the medical community in Germany after its publication. The legalization of medicalized killing was discussed and rejected at the 1921 *Karlsruhe Ärztetag*, medical convention, and at the 1922 Dresden conference of the Society for Forensic Psychiatry. Burleigh, *Death and Deliverance, supra* at 24.

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[9] As to the possibility of error, Binding writes: "the possibility of error by the Permission Board is undeniable. . . . But error is possible in all human actions." *Id.* at 254. He concludes: "all other actions of sympathy also involve possible error and perhaps an evil outcome. But who would want to limit the application of this most beautiful feature of human nature by pointing out such possible error?" *Id.* at 255.

Critics from the medical community warned that "compassionate" release for the afflicted would only be the first step toward a new medical ethic of death. Dr. M. Beer wrote in his book, *Ein schöner Tod: ein Wort zur Euthanasie-frage* 9 (Barmen 1914)(A Beautiful Death: A Word About the Question of Euthanasia), that physician aid-in-dying might be

> the first step, but whether it would be the last appears to me to be very doubtful. . . . Once respect for the sanctity of human life has been diminished by introducing voluntary mercy killing for the mentally-healthy incurably ill, and involuntary killing for the mentally ill, who is going to ensure that matters stop there?

Burleigh, *Death and Deliverance, supra* at 15. Critics of Hoche and Binding also

> despised the "utilitarian shopkeeper" mentality which appeared to inform the tract . . . Others worried about the inflationary, slippery-slope potentialities latent in the whole enterprise. A few had doubts regarding the inherent arbitrariness and perniciousness of value judgments regarding the value of human life.

Id. at 21.

In a major response to Hoche and Binding, *Das Problem der Abkürzung "lebensunwerten" Lebens (1925) (The Problem of Cutting Short Life Unworthy of Living)*, Dr. Ewald Meltzer hotly disputed the claim that

> people with mental handicaps had lost the last vestiges of human personality, stressing instead their capacity and will to enjoy life. [He argued that it is] "far more heroic to accept these beings to the best of one's abilities, to bring sunshine into their lives, and therewith to serve humanity" than to kill them for utilitarian reasons . . . altruism was humanity's distinguishing feature, [and] asylums for handicapped people were not only valuable centres of scientific research, but also tangible manifestations of Christian charity.

Burleigh, *Death and Deliverance, supra* at 21-22 (citations omitted).

While Binding and Hoche "turned out to be the prophets of direct medical killing," their thesis remained a minority view within German psychiatry and medicine during the Weimar Republic. Lifton, *The Nazi Doctors, supra* at 48. The rise of the Nazis brought into power an ideology of eugenics that provided the environment for their thesis, with the willing cooperation of medical and academic leaders, to overcome the initial opposition. *Id.* at 22-44. The first manifestation of this policy of "negative eugenics" was the mandatory sterilization of the "unfit;" acceptance of medical killing was the critical second step. *Id.* at 42-44.[10]

3. Cultural Responses.

Eugenicist theories promoting sterilization and euthanasia were widely propagated in German society through education and other means. Among the most prominent means used was film. In his novel *Mission and Conscience* (1936), later a popular film entitled "I Accuse," Helmut Unger told a story of a young woman suffering from multiple sclerosis who believes that her life is no longer worth living and asks her physician husband to relieve her of her misery.

> In a grand act of humanity, the husband gives his wife a fatal injection of morphine, while a friend of his (also a

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[10] As a consequence of these developments, the Ministry of Justice proposed in 1933 that it "be made possible for physicians to end the tortures of incurable patients, upon request, in the interests of humanity." Gallagher, *By Trust Betrayed, supra* at 93. The penal code would be revised to permit physician aid-in-dying upon approval of a three-physician review panel. *Id.* The law was not enacted; indeed, at no time were German laws amended or repealed in order explicitly to legitimate medical killing.

> doctor) accompanies the act with soothing and romantic music at the piano. [When he is brought to trial for murder, the husband] refuses to let his colleagues invent an alibi for him, because he is convinced he has done no wrong. [He is] acquitted on grounds that his act constituted an act of mercy [and] in a critical scene, the words of the Renaissance physician Paracelsus are recalled: "medicine is love."

Proctor, *Racial Hygiene, supra* at 182-83.

Several other pro-euthanasia films were produced during this period. *See* Burleigh, *Death and Deliverance, supra* at 183-219. The films argued that a medical ethic of preserving life only caused unnecessary pain and misery; "we humans use science to prolong suffering, where we could use science to bring deliverance." *Id.* at 204 (quotation from film). Such an ethic, these films said, stemmed from an "exaggerated concern for humanity," combined with "a religion which is alienated from reality," and "the dictates of an outmoded legal code", and which ought to be abandoned. *Id.* at 201-05 (quotations from films). Later, the key role of such images in leading to the acceptance of medical killing became apparent.[11]

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[11] One of the persons involved in these physician-assisted death programs was Alfons Klein, supervisor at Hadamar Sanitorium. His attorney described the course of events leading up to wholesale slaughter.

> In a motion picture called "I Accuse" the problem of euthanasia, that is mercy killing, was expounded. This picture was simply a prelude for things to come, because shortly after the beginning of the war the government passed a law whereby people who were afflicted mentally should be put out of the way. . . . from January 1941 to July 1945, more than 10,000 German mental patients were killed in Hadamar alone.

The Hadamar Trial, infra at 220-21. Counsel for Hadamar defendant Dr. Adolf Wahlmann further described what has to happen in the elite German medical community.

> The opinion was held in important circles that people of so low a physical or mental standard that their lives were not worth living, and for whom there was no hope of recovery or of ability to work, should be removed after medical examination, especially when they themselves were a burden on their relatives and on the general public. . . . In Germany this point of view was put before the public through the media of books and movies, and was gradually recognized by widening circles.

The Hadamar Trial, infra at 226.

B. Direct Medical Killing Began With Permission for Physician-Assisted Death In the Cases of Incurable Infants and Adults and Rapidly Expanded to Other Categories of Patients.

The proposals of Hoche, Binding, and others in the German and international community in favor of physician aid-in-dying were put into practice in the 1930s. First, child euthanasia was permitted for disabled and "defective" infants and children. Soon thereafter, an adult program for an "easy death" for incurably sick and mentally ill Germans was instituted on grounds of compassion. Ultimately, the genocide that was the Final Solution grew out of these programs of medicalized killing.

This "euthanasia" program was motivated by a mixture of concerns, some statist and some humanitarian in nature. It is important to note, however, that racial and anti-Semitic sentiments played no role in the original design or implementation of this program. In fact, the German government "did not want to grant this philanthropic act to the Jews." *Brandt*, Nurem.Mil.Trib., *infra* at 877-80; Kamisar, *Non-Religious Views, supra* at 470; Gallagher, *By Trust Betrayed, supra* at 69 (Viktor Brack maintained, "the blessing of euthanasia should be granted only to [true] Germans"). "[I]t is worth remembering that the engine which drove the early moral transformation of German medicine was not the

ideology of racial discrimination, but medical economics." Derr, *supra,* 8 Issues in Law & Med. at 494.

> [The] moral collapse of German medicine was not caused by anti-Semitism. Ironically, [Jews] did not deserve the 'benefit' of psychiatric euthanasia. [Nor was the collapse] caused by National Socialist pressure. . . . the collapse did not begin with the hacks and quacks. It began at the top, with the heads of departments of academic medicine.

Id. at 488-89.[12]

Furthermore, it is critical to note that physicians were invited, not compelled or otherwise forced, to participate in this program. Gallagher, *By Trust Betrayed, supra* at 60. "Doctors were never *ordered* to murder psychiatric patients and handicapped children. They were *empowered* to do so, and fulfilled their task without protest, often on their own initiative." Proctor, *Racial Hygiene, supra* at 193; *see also* Gallagher, *supra* at 5, 46.

1. Merciful Deaths for Children.

The practice of euthanasia, as illustrated by two early cases, began with requests from individuals for physician-assisted death. In March 1937, a child was killed by his father because he was significantly mentally ill. When put on trial for murder, the local health office came to the father's defense, influencing the court to grant him a nominal prison sentence instead of the death penalty asked for by the prosecutor. Proctor, *Racial Hygiene, supra* at 182.

The next year, a man named Knauer wrote the German government asking that his blind and mentally retarded

[12] "It would be a mistake to call it a Nazi program. It was not. The program was conceived by physicians and operated by them. They did the killing." Gallagher, *By Trust Betrayed, supra* at 5.

daughter, born without an arm and leg, be granted *Gnadentod* (mercy death). The Chancellor instructed his personal physician, Dr. Karl Brandt, to investigate, and, if the letter were true, to grant the request. Proctor, *Racial Hygiene, supra* at 186; Burleigh, *Death and Deliverance, supra* at 93-96. Brandt found "a child who was born blind, an idiot—at least it seemed to be an idiot—and it lacked one leg and part of one arm." Gallagher, *By Trust Betrayed, supra* at 47; Proctor, *Racial Hygiene, supra* at 186. According to the testimony of Brandt, "The parents should not feel themselves incriminated at some later date as a result of this euthanasia—that the parents should not have the impression that they themselves were responsible for the death of this child." Alexander Mitscherlich, *The Death Doctors* (1962) (James Cleugh, trans.) at 234.

Many parents were eager to obtain the *Wohltat* of physician-assisted death for their ill, deformed, or disabled children and many "wrote to hospitals to ask if their child could be relieved of his or her misery and be granted euthanasia." Proctor, *Racial Hygiene, supra* at 194; Kamisar, *supra*, 42 Minn. L. Rev. at 1032-1033[13]

Both doctors and parents preferred to use euphemisms, to allow for psychological defense mechanisms of rationalization and denial of what really was happening. After taking a poll of parental opinion, it was determined by the government that, al-

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> The business of taking a sick child on a costly and fruitless round of visits to doctors and hospitals frequently seems to have worn down their patience. They had exhausted most of the options before they were promised specialist treatment for the child. . . . The initiative to consign a child to one of these clinics sometimes came from parents, some of whom, like the twenty-five-year-old mother of a blind and mentally handicapped four-year-old child, were already of the opinion that it would have been better if the child had died at birth.

Burleigh, *Death and Deliverance, supra* at 101.

though many supported *Gnadentod* for their severely disabled children, "parents would prefer it if they were told that their child had succumbed to this or that illness." Burleigh, *Death and Deliverance, supra* at 98.[14]

As many as 6,000 children were provided the "benefit" of euthanasia in this first phase of physician-assisted death in Germany. *Id.* at 111; Lifton, *The Nazi Doctors, supra* at 50, 56.

2. T-4 Program: Euthanizing of Terminally Ill, Disabled, and Mentally Incompetent German Patients.

The German government also received requests from adults with cancer and severe disabilities for a mercy death. Burleigh, *Death and Deliverance, supra* at 93. Numerous people, believing that they were acting with compassion, wished that their handicapped relatives could be "released from their suffering." Henry Friedlander, *The Origins of Nazi Genocide: From Euthanasia to the Final Solution* 171-72 (1995).

In May 1939, an advisory group, the Committee for the Scientific Treatment of Severe and Genetically Determined Illness, was formed to determine if and how a euthanasia program for children and adults would operate. Proctor, *Racial Hygiene, supra* at 186. The adult project was housed in Berlin at number 4 Tiergartenstrasse, giving rise to its code-name "T-4." In the beginning, there appeared to be a broad level of support for this throughout the country. *Id.* at 194.

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[14] Few parents, however, were as explicit as a woman who requested that the Ministry of the Interior "have her two 'idiotic children' taken to the asylum at Schleswig 'in order to carry out euthanasia." *Id.* at 102.

Patients then began to be euthanized by lethal injection at various hospitals and other health care institutions. The T-4 doctors did not consider themselves to be killers, but ministers of medical treatment, although there was some concern that their actions be accorded some legitimate legal authority. Friedlander, *The Origins of Nazi Genocide, supra* at 300.

In September 1939, the chancellor responded to pressure to provide legal immunity for the doctors engaged in *Gnadentod* mercy killings and he issued a memorandum stating that

> Reichsleiter [Philip] Bouhler and Dr. [Karl] Brandt, M.D. are charged with the responsibility of enlarging the authority of certain physicians, to be designated by name, in such a manner that persons who, according to human judgment, are incurable can, upon a more careful diagnosis of their condition of sickness, be accorded a mercy death.

United States v. Brandt et al., Trials of War Criminals Before the Nuremberg Military Tribunals Under Control Council Law No. 10, Nuremberg, October 1946-April 1947, Vol. II:196.

This edict, however, did not have the force of law, even under the standards of the Nazi regime. Burleigh, *Death and Deliverance, supra* at 112-113. Another law to explicitly legalize physician-assisted death was proposed in 1940. Like the version proposed in 1933, it provided that

> Anyone suffering from an incurable illness that leads to strong debilitation of either oneself or others can, upon explicit request of the patient and with the permission of a specifically appointed physician, receive dying help (*Sterbehilfe*) from a physician.

Proctor, *Racial Hygiene, supra* at 193; Burleigh, *Death and Deliverance, supra* at 98-99. An additional clause provided further that those people who were mentally incompetent to decide for themselves to exercise this new "right" were entitled to have others make that decision for them on their behalf. *Id.*

This law was never formally enacted because the decision was made "to keep the question of euthanasia a 'private matter'— between doctors and their patients." Proctor, *Racial Hygiene, supra* at 193. The German medical profession was determined to keep the practice in their hands alone. "The needle belongs in the hand of the doctor," said Viktor Brack, head of one euthanasia program in 1939. Karl Brandt agreed, stressing that "gassings should only be done by physicians." Proctor, *Racial Hygiene, supra* at 190.

Government legal authorities initially intended that the T-4 program's *Sterbehilfe* would be lawful only for "those cases where physicians, upon their personal decisions, [can] relieve incurably ill patients from their suffering by administering a drug for mercy killing." Lifton, *The Nazi Doctors, supra* at 138-39. Within a short period of time, "a network of some thirty killing areas within existing institutions was set up."[15] Lifton, *The Nazi Doctors, supra* at 54; Burleigh, *Death and Deliverance, supra* at 101. Morphine, scopolamine, and prussic acid (cyanide) injections were initially used for the T-4 project because they had more of a "medical aura" than gas. However, objections to use of carbon monoxide gas were soon overcome because, not only was it more efficient, but Brandt said that carbon monoxide was painless and it "would be the most humane form of death." Lifton, *The Nazi Doctors, supra* at 72

[15] These hospitals and health-care facilities included Württemberg, Brandenburg, Hartheim, Sonnenstein, Hadamar, Leipzig-Dösen, Eglfing-Haar, Meseritz-Obrawalde, Tiegenhof, Langenhorn, Bernburg, Eichberg, Kalmenhof, Uchtspringe, Königslutter, Scheuern, Mainkofen, Am Steinhof, and Kaufbeuren. Friedlander, *The Origins of Nazi Genocide, supra* at 87-89, 95, 152-53, and 162. In fact, the killing secretly continued at Kaufbeuren, Eglfing-Haar, and a few other hospitals for months *after* the war ended and Allied forces assumed control. Gallagher, *By Trust Betrayed, supra* at 249-50.

In January 1940, Brandt, Brack and others conducted the first large-scale test of assisted death for incurable adults in a psychiatric hospital near Berlin. Proctor, *Racial Hygiene, supra* at 189-90. It was a gassing process, which "included a fake shower room with benches, the gas being inserted from the outside into water pipes with small holes through which the carbon monoxide could escape." Lifton, *The Nazi Doctors, supra* at 71.

What occurred in the adult program is exemplified by the hospital at Hadamar, one of the major T-4 institutions. Between January and August 1941, over 10,000 mentally ill Germans were provided a "painless death" in the shower-room gas chambers at Hadamar. *The Hadamar Trial: Proceedings of a Military Commission for the Trial of War Criminals,* Introduction at *xxiv* (E. Kintner ed. 1948).[16] An administrative supervisor at Hadamar was Alfons Klein. He testified at his war crimes trial that, from October 1940

> until January 1940 [The Hadamar] Institution was maintained only for German mental patients. In January 1941, plans were made to kill mental patients and to burn the corpses. This method was carried on and used until August 1941, when it was discontinued.

Id. at 69-70.

Heinrich Ruoff, chief male nurse who worked more closely with the patients, remembered that the T-4 program at Hadamar began slightly earlier.

[16] Counsel for Hadamar physician Adolf Wahlmann insisted at his war crimes trial that, "in general, the people killed were those faced with a permanent illness, for whom a completely painless death was a relief," *The Hadamar Trial, supra* at 228. "Insane people are useless to society and as a rule do not endure pain . . . Incurable tubercular patients, on the other hand, have to suffer terrific pain," added counsel for Heinrich Ruoff. *Id.* at 233.

> In 1940 the program of killing started. Those people who were brought here were German mentally sick. These people were gassed to death and then burned. . . . During the year 1941, because of complaints from Germans, this work was eliminated.

Id. at 75.

As Ruoff said, by 1941, word began to spread of involuntary killings. So, in August 1941, the psychiatric/physician-assisted death program at Hadamar and the other T-4 hospitals were officially ordered to be discontinued. By this time, 80,000-100,000 people had been killed under the T-4 program. Lifton, *The Nazi Doctors, supra* at 192; Burleigh, *Death and Deliverance, supra* at 160. At Hadamar, however, the program never ceased. Only the method of death changed; another 3,500 were euthanized by lethal injection between August 1941 and August 1942. *The Hadamar Trial, supra* at Introduction *xxiv*.

Beginning in 1942, the program recommenced elsewhere, except instead of gas, injections and starvation were the method of inducing death, largely on a case-by-case basis. Proctor, *Racial Hygiene, supra* at 192.[17]

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[17] About this point in time it was decided that German-held territory would be populated only by Germans. Ideas were circulated regarding the issue of what to do with Jews. *United States, et al. v. Hermann Goering, et al.*, 6 F.R.D. 69, 119 (1946) (judgment of the International Military Tribunal). Early measures included a requirement that all Jews must wear the Star of David, which was decreed in September 1941. Friedlander, *The Origins of Nazi Genocide, supra* at 288.

German-Jews had their citizenship revoked and were treated as foreigners; policies were "directed towards the complete exclusion of Jews from German life." *Goering*, 6 F.R.D. at 127. Deportations of Jews from the German homeland did not begin until October 1941. Friedlander, *The Origins of Nazi Genocide, supra* at 288. Jews were rounded up and imprisoned, and their property was seized. The "original purpose [of the concentration camps] was to imprison without trial all those persons who were opposed to the Government, or who were in any way obnoxious to German authority." *Goering*, 6 F.R.D. at 117. It was not until later that "camps became places of organized and systemic murder." *Id.*

It was not until March 1941 that the Frankfurt "Institute for the Investigation of the Jewish Question," was inaugurated. B. Müller-Hill, *Murderous Science* 45 (1988). Even then, Auschwitz survivor Prof. Henry Friedlander reports, "the policy toward Jews did not yet include killings." Friedlander, *The Origins of Nazi Genocide, supra* at 21.

3. Genocide Under 14f13: "Special Treatment" for Jews and Other "Undesirables."

World War II caused a change in emphasis and an acceleration of the killing process. Resources were scarce, and it was perceived that the armed forces had a greater claim to food, clothing, and medicine than did the sick, mentally ill, and social undesirables. The government accordingly took advantage of the distractions of the war to eliminate these "burdensome" people.

"The original 'euthanasia' project, the killing of those who were seriously ill [T-4], was extended to killing virtually anyone whose death was desired." Lifton, *The Nazi Doctors, supra* at 255. First, hospitalized Jews who had previously been denied a mercy death were given *Sonderbehandlung*, "special treatment," and killed along with Germans in the euthanasia program. Later, it was ordered that Jews and other undesirables be transported from the concentration camps to the same killing centers used by the T-4 program. Lifton, *The Nazi Doctors, supra* at 134-44; Burleigh, *Death and Deliverance, supra* at 132-33.

Overall, it is estimated that 5,000 were provided a "mercy" death in the child operation, 80,000 to 100,000 in the adult T-4 program, 20,000 concentration camp inmates in the 14f13 project; "special treatment" against Jews in hospitals

eliminated another 1,000. Friedlander, *The Origins of Nazi Genocide, supra* at 150; Lifton, *The Nazi Doctors, supra* at 142. Some estimate the total toll of physician-assisted death was 275,000. Alexander, *Medical Science Under Dictatorship, supra*, 241 New Eng. J. Med. at 45-46. Other estimates reach as high as 400,000, from the child euthanasia, T-4, *Sonderbehandlung*, and 14f13 operations combined. Lifton, *The Nazi Doctors, supra* at 142. The true number of lives lost can never be known.[18]

III. TESTIMONY FROM THE TRIALS OF MEDICAL KILLINGS IN GERMANY PROVES THE NECESSITY OF AN ABSOLUTE PROHIBITION AGAINST KILLING BY PHYSICIANS.

Perhaps the best evidence for concluding that society must refrain from permitting any degree of killing by physicians is the testimony of those who participated in these crimes, as well as those who investigated and prosecuted them.

German physicians and other health care workers were put on trial for murder, crimes against humanity, and war crimes for their participation in the child euthanasia, T-4, 14f13, and "special treatment" projects.[19] Throughout these trials, the

[18] On January 20, 1942, nearly four years after the euthanasia program for Germans began with the *Gnadentod* of the Knauer child, the plans for the Final Solution of the "Jewish Problem" were completed at the Wannsee Conference, a meeting of thirteen high-ranking government officials. Proctor, *Racial Hygiene, supra* at 210; Lifton, *The Nazi Doctors, supra* at 158. But even then, "during early 1942, the details of the killing procedure were not yet clear, and were not solved until spring with the establishment of gas chamber camps in Poland." Lifton, *The Nazi Doctors, supra* at 158.

[19] Prof. Friedlander reports that

> a massive documentary record substantiate[s] the nature of these crimes. In addition to the Allied, German, and Austrian trials of the late 1940s, the German judiciary had conducted numerous detailed investigations and long trials during the 1960s and 1970s.

defendants insisted that their actions were motivated by compassion and humanitarian concerns. Valentin Faltlhauser insisted that, for him, "the decisive motive was compassion." Burleigh, *Death and Deliverance, supra* at 277. Pediatrician Ernst Wentzler recalled, "I had the feeling that my activity was something positive, and that I had made a small contribution to human progress." *Id.* at 100.

Also prevalent was the sentiment that, as physicians, these defendants' actions ought not be scrutinized by lawyers and judges. Dr. Hermann Pfannmüller, medical director at the Elgfing-Haar asylum hospital, complained at his trial before the Nuremberg Tribunal: "I am a doctor confronted with a lawyer and our points of view are completely divergent." Burleigh, *Death and Deliverance, supra* at 273.

Dr. Karl Brandt, who had played a critical role in the original authorization of the euthanasia program, spoke most directly in defense of its legitimacy, arguing through his attorney it was within the authority of the state to institute such a program. Nurem. Mil. Trib. II:135. In the closing argument for his case, Brandt made the following personal statement:

> Do you think that it was a pleasure for me to receive the order to permit euthanasia? For fifteen years I had toiled at the sickbed and every patient was to me like a brother. I worried about every sick child as if it had been my own. . . . I fully realize the problem; it is as old as mankind, but it is not a crime against man nor humanity. It is pity for the incurable, literally. Here I cannot believe like a clergyman or think as a jurist. I am a doctor and I see the law of nature as being the law of reason. In my heart there is a love of mankind, and so it is in my conscience. That is why I

Friedlander, *The Origins of Nazi Genocide, supra* at Preface *xi*. For a listing of over sixty various post-war German court cases and prosecutions for murder for participation in the euthanasia programs, see Friedlander, *The Origins of Nazi Genocide, supra* at 387-89.

> am a doctor! . . . Death can mean deliverance. Death is life—just as much as birth. It was never meant to be murder.

Nurem. Mil. Trib. II:139.

Similar arguments were put forth by Alfons Klein and other defendants at the Hadamar trial. Klein insisted that it was only in extreme cases, such as those involving the final stages of tuberculosis, that patients were "helped along" and saved from an insufferable prolonged death. "Only those people died who were very close to death already." *The Hadamar Trial, supra* at 88.

> One must therefore, in judging the facts, differentiate whether healthy, valuable lives were left to die, or whether those who had death stare into their face were given an injection of mercy to relieve them of their incurable and painful suffering. . . . I can say that the people were very ill and were saved from their suffering.

Id. at 102-03. Other Hadamar defendants justified the killings as acts of "mercy" and "deliverance." Burleigh, *Death and Deliverance, supra* at 152, 160.

The War Crimes tribunals invariably rejected these defenses. Nevertheless, they are indicative of the attitude that the defendants brought to their work in asylums and hospitals, an attitude which some specifically attributed to Hoche and Binding, and others to the general current of thought in German society. The attitude was shared by those who escaped punishment after the War. For example, Dr. Werner Catel, a "referee" in the T-4 program, later published a book advocating the "mercy killing" of severely defective infants. Burleigh, *Death and Deliverance, supra* at 284-285. In the last of the major euthanasia trials, in 1986, the defendants repeated the refrain that they had killed "out of love and pity." *Id.* at 289. These latter-day restatements of the (failed) defenses offered by defendants of 40 years earlier suggests a level of

sincerity inconsistent with the theory that these attempted justifications had been manufactured after the fact out of mere expediency. The perpetrators believed in the notion of "life unworthy of living" before, during, and after their horrendous crimes.

Those who investigated and prosecuted these crimes accepted the fact that these physicians had been corrupted, not merely by Nazi ideology, but first by acceptance of a fundamental change in attitude regarding the role of the physician toward the chronically sick.

U.S. Brigadier General Telford Taylor, chief of counsel for the prosecution, described the prominent physicians who were tried and convicted of murder:

> The defendants . . . are charged with murder, tortures and other atrocities committed in the name of medical science. . . .[They] did not kill in hot blood, nor for personal enrichment . . . they are not all perverts. They are not ignorant men. Most of them are trained physicians and some of them are distinguished scientists. The perverse thoughts and distorted concepts which brought about these savageries are not dead. They cannot be killed by force of arms. They must not become a spreading cancer in the breast of humanity. They must be cut out and exposed.

Nurem. Mil. Trib. I:66-71.

Dr. Leo Alexander noted the origin and persistence of such ideas in the wake of his experience as a medical expert at the Nuremberg medical trials:

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude,

basic in the euthanasia movement, that there is such a thing as a life not worthy to be lived.

Alexander, *supra*, 241 New Eng. J. Med . at 44.[20]

Justice Robert Jackson, Chief of Counsel for the United States at Nuremberg Trial of Major German War Criminals, also observed the corruptive influence of accepting medical killing even in so-called "hard" cases:

> To begin with, [the Hadamar euthanasia program] involved only the incurably sick, insane and mentally deficient patients of the Institution. It was easy to see that they were a substantial burden to society, and life was probably of little comfort to them. It is not difficult to see how, religious scruples apart, a policy of easing such persons out of the world by a completely painless method could appeal to a hard-pressed and unsentimental people. But "euthanasia" taught the art of killing and accustomed those who directed and those who administered the death injections to the taking of human life. Once any scruples and inhibitions about killing were overcome and the custom was established, there followed naturally an indifference as to what lives were taken. Perhaps also those who become involved in any killings are not to be in a good position to decline further requests. If one is convinced that a person should be put out of the way because, from no fault of his own, he has ceased to be a social asset, it is not hard to satisfy the conscience that those who are wilful enemies of the prevailing social order have no better right to exist. And so Hadamar drifted from a hospital to a human slaughterhouse.

---

[20] In the last year of his life, Dr. Alexander drew explicit links between the German experience he had studied so extensively and the advocacy for legalized euthanasia in the United States: "It is much like Germany in the Twenties and Thirties. The barriers against killing are coming down." Patrick G. Derr, "The Real Brophy Issue," *Boston Globe* 15 (Nov. 18, 1985).

Forward to *The Hadamar Trial, supra* at *xiv.*

In conclusion, Justice Jackson issued a warning that should not be lost in the midst of arguments that American medicine would not be corrupted by the legalization of physician-assisted suicide:

> A freedom-loving people will find in the records of the war crimes trials instruction as to the roads which lead to such a regime and the subtle first steps that must be avoided.

Id.

CONCLUSION

Frustrated with the ethic of "preserving every existence, no matter how worthless," Dr. Alfred Hoche in 1920 wrote, expectantly: "A new age will arrive—operating with a higher morality and with great sacrifice—which will actually give up the requirements of an exaggerated humanism and overvaluation of mere existence." 8 Issues in Law & Med. at 265. Euthanasia proponents of our day, too, seek with great zeal to usher in a new age. They speak, in words echoing from a distant age, that it is cruel to deprive those who are suffering from their desired means to peace and freedom from pain. Like Binding, they scold: "Not granting release by gentle death to the incurable who long for it: this is no longer sympathy, but rather its opposite." *Id.* at 254.

The early promoters of euthanasia appeared to be sincere in their belief in the virtues of merciful death. Today's promoters of physician-assisted suicide may also be sincere, but it is a sincerity born of an unpardonable carelessness. Unlike their predecessors, euthanasia proponents today have the benefit of the lesson of history, which has taught the true nature of physician-assisted killing as a false compassion and a perversion of mercy. History warns that the institution of assisted-death gravely threatens to undermine the foundational ethic of

the medical profession and the paramount principle of the equal dignity and inherent worth of every human person.

The decisions of the Second Circuit and the Ninth Circuit should be reversed, and the complaints dismissed.

Respectfully submitted,

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Respondents.

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BRIEF OF AGUDATH ISRAEL OF AMERICA AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

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30 pp

TABLE OF CONTENTS

Page

TABLE OF CONTENTS i

TABLE OF AUTHORITIES ii

INTEREST OF THE AMICUS CURIAE 1

ARGUMENT 5

I. LEGALIZING ASSISTED SUICIDE, IN ANY FORM, COULD LEAD TO TRAGIC ABUSE 7

II. THE DECISIONS BELOW, IF AFFIRMED, ARE LIKELY TO LEAD TO A BROAD EXPANSION OF THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA 9

1. The Ninth Circuit's Candid Acknowledgments . 10

2. Implications of the Second Circuit's Equal Protection Analysis 15

III. ASSIGNING DIMINISHED LEGAL PROTECTION TO A LIFE OF DIMINISHED MEDICAL QUALITY FOLLOWS DANGEROUS HISTORICAL PRECEDENT 21

CONCLUSION 25

TABLE OF AUTHORITIES

Cases **Page(s)**

Bisenius v. *Karns*, 165 N.W. 2d 377,
appeal dismissed 365 U.S. 709 (1969) 8

Compassion in Dying v. *State of Washington*,
79 F.3d 790 (9th Cir. 1996) (en banc),
request for rehearing denied,
85 F.3d 1440 (9th Cir. June 12, 1996) . . . . . 5, *passim*

Compassion in Dying v. *State of Washington*,
49 F.3d 585 (9th Cir. 1995) 6

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497 U.S. 261 (1990) 2,20,21

In re Guardianship of Grant,
747 F.2d 445 (Wash. 1987) 12

Hooper v. *Bernalillo County Assessor*,
472 U.S. 612 (1985) 16

Jacobson v. *Massachusetts*,
197 U.S. 11 (1905) 8

Jeovahs Witnesses v. *King County Hospital Unit*,
390 U.S. 598 (1968) 8

People v. *Kevorkian*, 447 Mich. 436 (1994),
cert. denied 115 S. Ct. 1795 (1995) 6

Planned Parenthood of Southeastern Pennsylvania v. *Casey*,
505 U.S. 833 (1992) 2,6

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410 U.S. 113 (1973) 8

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211 N.Y. 125 (1914) 18

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cert denied, 424 U.S. 954 (1976) 8

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454 U.S. 858 (1981) 18

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492 U.S. 490 (1989) 2

Matter of Westchester County Medical Center,
72 N.Y. 2d 517 (1988) 19

Statutes

N.Y. Public Health Law § 2982 (McKinney's 1993) 19

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BRIEF OF AGUDATH ISRAEL OF AMERICA AS AMICUS CURIAE IN SUPPORT OF THE PETITIONERS

INTEREST OF THE AMICUS CURIAE

Agudath Israel of America, a national grassroots Orthodox Jewish movement founded in 1922, is deeply concerned about the rulings below and the broader

implications they hold for the future, and respectfully submits this brief as *amicus curiae* in support of the respective petitioners.

Informed by classical Jewish tradition which teaches that all human life is sacred, and possessed of the firm view that laws and judicial rulings that undermine the sanctity of human life send a message that is profoundly dangerous for all of society, Agudath Israel speaks out frequently, in a variety of legal and policy settings, on a broad array of issues that arise at the onset and conclusion of the human life cycle. In this court, for example, Agudath Israel has submitted briefs as *amicus curiae* in the abortion rights cases of *Webster* v. *Reproductive Health Services* (decision reported at 492 U.S. 490 (1989)) and *Planned Parenthood of Southeastern Pennsylvania* v. *Casey* (decision reported at 505 U.S. 833 (1992)); and -- more directly relevant to the issues involved in the instant case -- in the "right to die" case of *Cruzan* v. *Director, Missouri Department of Health* (decision reported at 497 U.S. 261 (1990)).

Agudath Israel's interest in the issue of physician assisted suicide is especially keen. It is a basic principle of Jewish law and ethics that "[m]an does not possess absolute title to his life or body." J.D. Bleich, *The Quinlan Case: A Jewish Perspective*, reprinted in *Jewish Bioethics* 266, 270 (Hebrew Publishing Co. 1979). Agudath Israel believes that recognition of that teaching, as expressed in the historical disapprobation of suicide and euthanasia, has served as one of the pillars of civilized societies throughout

the generations. That pillar is now in peril.*

It is yet another principle of Jewish law and ethics that a doctor's role is to provide healing, not to hasten death. *See* I. Jakobovits, *Regarding the Law Whether it is Permitted to Hasten the End of a Terminal Patient in Great Pain*, 31 *Ha-pardes* 29 (1956). Doctors who assist in the commission of suicide, even when motivated by the most humane of concerns, exceed the bounds of their own Hippocratic mandate and undermine public confidence in the medical profession. Anthropologist Margaret Mead -- herself a supporter of certain forms of euthanasia, so long as they are under lay initiative and control -- has urged that "the medical profession should not be compromised by participation" in euthanasia; "[t]he physician's dedication to the saving of life is of incalculable value to humanity and must be protected from repeated efforts to involve the doctor in lethal activities." M. Mead, *From Black and White Magic to Modern Medicine*, 22 Proceedings of the Rudolf Virchow Medical Society 131 (1965). Agudath Israel views with considerable alarm the transformation of the physician's calling envisioned by the decisions below.

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* To the extent the Ninth Circuit below meant to suggest that Judaism "views suicide with equanimity or acceptance," *Compassion in Dying* v. *Washington*, 79 F.3d 790, 807 n.24 (1996) (*see also id.* at 808 n.25), the court was simply wrong. The general rule is that suicide and its facilitation are strictly forbidden under Jewish law, no matter how unbearable life may have become. *See generally* F. Rosner, *Modern Medicine and Jewish Ethics*, 225-39 (Ktav Publishing House, Yeshiva University Press 1986).

Moreover, as representatives of a people whose numbers were decimated little more than half-a-century ago by a society that "progressed" from its "enlightened" practices of "mercy killing" to the mass slaughter of millions of human beings deemed physically or racially "inferior," Agudath Israel is particularly sensitive to the legal assignment of diminished levels of life protection based on diminished levels of life "quality". The decisions below reflect this dangerous trend away from the recognition of life's inherent sanctity and present a stark challenge to our nation's social morals.

Agudath Israel submits this brief upon the consent of all parties.

ARGUMENT

The two federal circuit courts below -- the Ninth Circuit in *Compassion in Dying* v. *State of Washington*, 79 F.3d 790 (9th Cir., March 6, 1996) (*en banc*), *request for rehearing denied,* 85 F.3d 1440 (9th Cir. June 12, 1996); and the Second Circuit in *Quill* v. *Vacco*, 80 F.3d 716 (2d Cir., April 2, 1996) -- found as-applied constitutional infirmities in Washington and New York state statutes that make it a crime to "aid" another individual in committing or attempting to commit suicide. The two rulings reached similar (though not identical) bottom lines, but arrived at their destinations through different constitutional routes.

The Ninth Circuit found a due process "liberty interest in choosing the time and manner of one's death," 79 F.3d at 798; and determined, in the context of "competent, terminally ill adults who wish to hasten their deaths by obtaining medication prescribed by their doctors," that such due process liberty interest outweighed any countervailing interest asserted by the state. *Id.* at 838.

The Second Circuit, in contrast, relied on the equal protection clause in holding that physicians are constitutionally permitted to "prescribe drugs to be self-administered by mentally competent adults who seek to end their lives during the final stages of a terminal illness." 80 F.3d at 718. Such persons, reasoned the court, are "similarly circumstanced" to final-stage terminally ill patients who enjoy the statutory and common law right to hasten their death by authorizing termination of life support, *id.* at 729; and, the court concluded, there is no legitimate state interest rationally served by distinguishing between the two categories. *Id.* at 730-31.

Both grounds of decision, Agudath Israel submits, are wrong. The better of the legal argument, we believe, is with the dissenting judges in the Ninth Circuit *en banc* decision (79 F.3d at 839 (Beezer, J.), 857 (Fernandez, J.) & 857 (Kleinfeld, J.)); with the dissenting judges in the Ninth Circuit's subsequent rejection of a request to have the *en banc* decision reheard by the full circuit court (85 F.3d at 1440 (O'Scannlain, J.), 1446 (Trott, J.)); with the Ninth Circuit's earlier panel in *Compassion in Dying* v. *State of Washington*, 49 F.3d 585 (9th Cir. 1995); with the district court in *Quill* v. *Koppell*, 870 F.Supp. 78 (S.D.N.Y. 1994); and with the Michigan Supreme Court in *People* v. *Kevorkian*, 447 Mich. 436 (1994), *cert. denied* 115 S. Ct. 1795 (1995). With respect to the due process argument, we share the view of these judges and courts that this Court's broad dictum in *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 851 (1992) -- identifying "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" as being "at the heart of liberty" -- does not elevate assisted suicide to the status of a constitutionally protected right. With respect to the equal protection argument, we contend, as have many courts, legislative and executive bodies, medical associations and bioethical experts, that there is a sound basis of legal distinction between what one commentator has termed "letting the patient die" and "making the patient die" S.L. Carter, *The Culture of Disbelief* 236 (Basic Books 1993) -- though we also believe there can and should be legal restrictions on the authority of patients and their surrogates even to decline life support.

Mindful of the admonition that "[a]n *amicus* brief which does not serve [the purpose of bringing relevant

matter to the attention of the Court that has not already been brought to its attention by the parties] simply burdens the staff and facilities of the Court and its filing is not favored," Rule 37.1, *Rules of the Supreme Court of the United States* (1990), we will not belabor the reasons we think the constitution does not create any right to assisted suicide; they are well articulated in the decisions and opinions cited in the preceding paragraph, and are sure to be further developed by the petitioners themselves.

The focus of our argument, therefore, will be not on why we think the decisions below are *bad* law, but why we think they are *dangerous* law. The legalization of assisted suicide, even in the narrow contexts addressed by the decisions below, has the potential to lead to tragic abuse (Point I, *infra)*. Moreover, the Ninth and Second Circuit rulings portend a far-reaching relaxation of laws against assisted suicide and euthanasia, in contexts very different than those in which the two cases arose (Point II, *infra*). Perhaps most troubling, the two courts' determination that lives of diminished "quality" are entitled to diminished constitutional protection ignores some important lessons of 20th century history that deserve careful consideration (Point III, *infra)*.

I.

LEGALIZING ASSISTED SUICIDE, IN ANY FORM, COULD LEAD TO TRAGIC ABUSE

Agudath Israel takes both moral and legal exception to the notion that a person enjoys unfettered personal autonomy to decide that his life is no longer worth living. Society has the right to compel citizens to submit to

vaccination, *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905); to insist that a child receive life-sustaining treatment even over the religiously motivated opposition of his parents, *Jeovahs Witnesses* v. *King County Hospital Unit*, 390 U.S. 598 (1968); to prevent a pregnant woman in her second trimester from receiving an abortion in an unlicensed facility, *Roe* v. *Wade*, 410 U.S. 113, 163 (1973); to restrict the handling of poisonous snakes and drinking poisonous substances as part of a religious ceremony, *State ex rel. Swann* v. *Pack*, 527 S.W. 2d 99 (Tenn. 1975), *cert denied* 424 U.S. 954 (1976); to enact laws designed to protect users of highways "even against the consequences of their own action," *Bisenius* v. *Karns*, 165 N.W. 2d 377, 382, *appeal dismissed* 365 U.S. 709 (1969).

There are particularly strong reasons to reject the view that the generally accepted doctrine of personal autonomy in medical decision making should allow patients to enlist their doctors' help in committing suicide. The potential abuses of legalizing assisted suicide have been well catalogued by a host of legal and medical observers. For example, in its landmark report opposing assisted suicide, the 24-member New York State Task Force on Life and the Law, speaking unanimously, noted the following concerns: the pressures patients would feel, from their doctors and families, to opt for suicide; the inherent inequalities of our health care delivery systems which tend to discriminate against the poor, the handicapped and the elderly; the psychological vulnerability of the severely ill; the risk of misdiagnosis of the patient's condition; the likelihood in many cases that adequate treatment of pain and depression would dissuade the patient from seeking death. New York State Task Force on Life and the Law, *When Death is*

Sought: Assisted Suicide and Euthanasia in the Medical Context 121-34 (1994). Indeed, these risk factors will often raise serious doubts about whether a patient's request for help in committing suicide is truly an expression of the patient's autonomous will.

We concur with the Task Force's observation (Report at 121) that, "as a society, we have better ways to give people greater control and relief from suffering than by making it easier for patients to commit suicide or to obtain a lethal injection."

II.

THE DECISIONS BELOW, IF AFFIRMED, ARE LIKELY TO LEAD TO A BROAD EXPANSION OF THE RIGHT TO ASSISTED SUICIDE AND EUTHANASIA

On their faces, the Ninth and Second Circuit decisions are extremely narrow. They apply only to fully competent terminally ill patients (or, in the case of *Quill*, patients in the "final stages" of terminal illness) who have clearly expressed their desire to commit suicide, and who seek only such assistance from their physicians as is necessary for them to self-administer a lethal dosage of drugs. However, the *language* of the decisions (especially the expansive statements of the Ninth Circuit), and their *reasoning* (especially the equal protection analysis of the Second Circuit), could well result in the expansion of the right to assisted suicide and euthanasia far beyond the narrow confines in which the cases arose. The Court would do well to ponder the ultimate destination of the paths the Ninth and Second Circuits would have the constitution embark.

1. The Ninth Circuit's Candid Acknowledgments

The three patient-plaintiffs in *Compassion in Dying* (in this Court as *Glucksberg*) were mentally competent, whose illnesses were deemed "terminal" because their doctors had concluded they were irreversible and would likely cause death within a relatively short time, and who clearly articulated their desire to have their doctors furnish them with a lethal dosage of medication for their own self-administration. The Ninth Circuit, however, candidly acknowledged that its ruling in their favor was not so narrowly limited.

For one thing, said the court, it is not only doctors whose prescriptive services are protected by the constitutional right to assisted suicide, but also "those whose services are essential to help the terminally ill patient obtain and take [the lethal prescription] and who act under the supervision or direction of a physician... That includes the pharmacist who fills the prescription; the health care worker who facilitates the process; the family member or loved one who opens the bottle, places the pills in the patient's hand, advises him how many pills to take, and provides the necessary tea, water or other liquids; or the persons who help the patient to his death bed and provide the love and comfort so essential to a peaceful death." 79 F.3d at 838 n.140. In addition, the court noted that its holding encompassed the decisions of persons who are terminally ill not only as that term is colloquially understood, but also as it is statutorily defined -- in Washington Sate, for example, persons who are in an irreversible coma or a persistent vegetative state, regardless of their life expectancy. 79 F.3d at 831.

Significant though these acknowledgements are, it is in two other respects that the Ninth Circuit's expansive articulation of its position is especially noteworthy: (a) the court's view on physician-administered poison; and (b) the court's recognition of the authority of surrogate decision makers.

(a) While the court expressly left for "future cases" the issue of a doctor's right to inject a lethal dosage into a patient incapable of self-administering the poison, it candidly indicated its view that this too would be constitutionally protected:

> "We do not dispute the dissent's contention that the prescription of lethal medication by physicians for use by terminally ill patients who wish to die does not constitute a clear point of demarcation between permissible and impermissible medical conduct. We agree that it may be difficult to make a principled distinction between physician-assisted suicide and the provision to terminally ill patients of other forms of life-ending medical assistance, such as the administration of drugs by a physician. We recognize that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them... We would be less than candid... if we did not acknowledge that for present purposes we view the critical line in right-to-die cases as the one between the voluntary and involuntary termination of an individual's life. In the first case — volitional death — the physician is aiding or assisting a patient who

> wishes to exercise a liberty interest, and in the other — involuntary death — another person acting on his own behalf, or, in some instances society's, is determining that an individual's life should no longer continue. We consider it less important who administers the medication than who determines the medication than who determines whether the terminally ill person's life shall end." 79 F.3d at 831-32 (footnotes omitted).

(b) The court emphasized that the constitutional demarcation it would draw between "volitional death" and "involuntary death" was not intended to imply that the right to request assistance in committing suicide is necessarily personal to the patient himself. "[W]e should make it clear," wrote the court, "that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." 79 F.3d at 832 n.120. (Indeed, noted the court, under certain circumstances, Washington law also regards the decisions of a legal guardian as the decision of the patient himself, 79 F.3d at 818 (citing, *inter alia*, *In re Guardianship of Grant*, 747 P.2d 445 (Wash. 1987), in which the Washington Supreme Court authorized a legal guardian to "make a good-faith determination of whether the withholding of life sustaining treatment would serve the incompetent patient's best interests" where the patient's own wishes cannot be ascertained, 747 P.2d at 457). Presumably, therefore, just as a duly appointed surrogate decision maker could request a lethal prescription on a patient's behalf, so too could a legal guardian in cases where his decisions are treated as the patient's own.)

It should be readily apparent that the Ninth Circuit's

caveat about the authority of surrogate decision makers undermines considerably its bright line distinction between "volitional death" and "involuntary death". Professor Tribe has summarized the three types of situations in which surrogate decision makers have exercised "substituted judgment" on behalf of incompetent patients:

> "There are basically three approaches courts have taken to decisionmaking in treatment decisions for incompetent patients. First, if the patient had when competent stated what decision she would have wanted made in this situation, those wishes tend to be deemed decisive. Second, where there is no direct evidence of the patient's preferences, if there is a relative or a friend who was close enough to the patient to be able to surmise how she would have decided, this relative or friend may be allowed to choose in the name of the patient. Third, if there is no basis for deciding what the patient would have decided, a decision is made according to what would be in the patient's 'best interests', as defined by the court, by the patient's family, or by a court-appointed guardian."

L. Tribe, *American Constitutional Law*, § 15-11 at 1368-69 (2d Ed. 1988) (footnotes omitted). As Professor Tribe points out, however, "*[a]ll three forms of 'substituted judgment' are at best imperfect ways to effectuate the patient's right of self-determination*. No matter how much evidence there is of subjective intent, how well the guardian knew the patient, and how well-intentioned the patient's guardian, family, and physician may be, *there will always*

be some residual doubt that the decision made in fact expresses what the patient would have wanted done." Id. at 1369 (emphasis added; footnote omitted).

In sum, the Ninth Circuit would apparently extend the constitutional right of assisted suicide to cases involving a surrogate decision maker's request, based on his admittedly imperfect knowledge of an incapacitated terminal patient's wishes, or perhaps even on his own assessment of the patient's best interests, to have a doctor *kill the patient*. This brings to mind a prescient passage elsewhere in Professor Tribe's treatise:

> "As courts become more sympathetic to arguments that persons have a right to die with dignity and that the state interest in the preservation of life may sometimes be subordinated to an individual's right to die, there is a possibility that doctrines which are intended to facilitate the exercise of this right will be exploited, either intentionally or unwittingly, to practice the most terrible discrimination against handicapped persons who require medical treatment to stay alive: judgments that their disabilities are such that persons afflicted with them would be better off dead and thus should be 'allowed' to die. The most pernicious discriminatory bias against the disabled that one can imagine -- the desire of families or others to dispose of handicapped persons whom they simply consider undesirable -- might be effectively disguised behind their requests, made in the name of the disabled's right to die, that

> medical treatment be withheld from the disabled. The right to die, in other words, may offer a convenient pretext for profoundly discriminatory decisionmaking."

L. Tribe, *supra,* § 16-31 at 1598-99 (footnotes omitted).

2. Implications of the Second Circuit's Equal Protection Analysis

The Second Circuit took pains to give its ruling a more moderate veneer than that of its sister court. The court expressly rejected any substantive due process right to assisted suicide, 80 F.3d at 723-25; determined that the equal protection claim would be judged under the less exacting standard of rational basis scrutiny, *id.* at 727; intimated that the right to assisted suicide would not authorize a physician to inject a lethal dosage into a patient incapable of self-administering the dosage, *id* at 730 n.3; said nothing about the right of a surrogate decision maker to request suicide assistance on behalf of an incapacitated patient; and limited the terms of its holding to patients in the final stages of terminal illness, *id.* at 731.

In fact, however, it may well be that the Second Circuit's ruling creates an even more expansive right to assisted suicide than does the Ninth Circuit's. That is because of a basic difference between the respective judicial inquiries under the due process and equal protection clauses.

As the Ninth Circuit pointed out, the due process constitutional claim of a patient seeking suicide assistance will be determined, like all substantive due process claims,

by weighing the strength of the various competing interests present in any given circumstance. The court's calibration of those competing interests led it to its bottom line determination: "The liberty interest at issue here...in the case of the terminally ill, is at its peak. Conversely, the state interests, while equally important in the abstract, are for the most part at a low point here." 79 F.3d at 837. While Agudath Israel believes, as elaborated *infra,* that the Ninth Circuit incorrectly undervalued the state's interest in preserving the life of even terminally ill persons there is at least some room for argument that the due process balancing framework will enable courts, in cases involving non-terminal patients where the balance of competing interests tips in favor of the state, to draw the line: "So far down the slope, but no farther." The equal protection framework embraced by the Second Circuit, in contrast, would appear to include no such line-drawing braking mechanism.

The relevant equal protection inquiry here is *not* how strong the state's interest is in preserving life in any given context, but whether treating "similarly circumstanced" persons differently is rationally related to a legitimate state interest. As the Court stated in *Hooper* v. *Bernalillo County Assessor*, 472 U.S. 612 (1985): "When a state distributes benefits unequally, *the distinctions it makes* are subject to scrutiny under the Equal Protection Clause of the Fourteenth Amendment. Generally, a law will survive that scrutiny if *the distinction* rationally furthers a legitimate state purpose." *Id.* at 618 (footnote omitted; emphasis added). Accordingly, once one accepts the Second Circuit's conclusion that a patient who seeks termination of life support and a patient who seeks poison are "similarly circumstanced persons" who must be treated identically

unless the state can demonstrate that treating them differently rationally advances a legitimate state interest, 80 F.3d at 729; and once one accepts the court's additional conclusion that no such rational basis of distinction exists when the two persons are in the final stages of terminal illness, *id.* at 730-31 -- there is no readily apparent logical way of drawing lines anywhere along the slope.

In reaching its holding that the prohibition against assisted suicide, as applied to final-stage terminally ill patients, violates the equal protection clause, the Second Circuit posed a series of dramatic questions, and an equally dramatic answer:

> "But what interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes... And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? What concern prompts the state to interfere with a mentally competent patient's 'right to define [his] own concept of existence, of meaning, of the universe, and of the mystery of human life' [citation omitted]. when the patient seeks to have drugs prescribed to end life during the final stages of a terminal illness? The greatly reduced interest of the state in preserving life compels the answer to these questions: 'None.'" 80 F.3d at 729-30.

The questions are indeed dramatic, and so is the response -- but they are also highly misleading. For they imply that the equal protection analysis would be different in cases where the state's interest in preserving life would

be stronger than the Second Circuit deems it to be at the final stages of terminal illness. In fact, however, since the relevant inquiry is not whether the state has a rational basis to preserve life, but whether it has a rational basis to *distinguish* between patients who refuse life support and patients who seek the means to commit suicide, it should make no equal protection difference whatsoever how far along the patient's terminal illness has progressed, or even whether he is terminally ill altogether. The strength of the state's interest in preserving life is simply not relevant to the equal protection inquiry, for it does not speak to any distinction the law might draw between the two patients "similarly circumstanced."

The implication of the Second Circuit's ruling, therefore, is that *wherever* the law permits an individual to forgo life support, equal protection demands that it also permit him to request a lethal prescription. The Second Circuit's apparent moderation is only skin deep; beneath its deceptively mild surface lies constitutional radicalism.

Consider the body of New York law implicated most directly by the ruling below. The right of competent persons to decline or discontinue life-sustaining medical intervention was first established at common law in *Schloendorf* v. *Society of New York Hospital*, 211 N.Y. 125, 129 (1914), where Judge Cardozo enunciated the basic doctrine of personal autonomy in medical decision-making: "[E]very human being of adult years and sound mind has a right to determine what shall be done with his body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *In re Storar*, 52 N.Y. 363, 376-77, *cert. denied*, 454 U.S. 858 (1981), makes clear that the common

law right of personal autonomy includes the right to refuse treatment necessary to preserve one's life. The New York courts have not limited such right to patients who are terminally ill -- certainly not to patients who are in the final stages of their terminal illness. Given the Second Circuit's rejection of any distinction between refusing life support and requesting poison, if a young patient with a good prognosis for recovery enjoys the common law right to refuse a life-saving operation, should he not also enjoy the right to a lethal prescription?

The same question will apply when a third party is legally authorized to make a decision on an incapacitated patient's behalf. Under New York common law, "the right to decline treatment is personal and...could not be exercised by a third party when the patient is unable to do so" unless there is "clear and convincing evidence" that the incapacitated patient would have refused life support. *Matter of Westchester County Medical Center*, 72 N.Y. 2d 517, 528-29 (1988). New York's legislature, however, has started moving away from the "clear and convincing evidence" standard. Most notably, in 1990, a statute was enacted empowering a duly designated health care agent to make virtually any life-and-death treatment decision on behalf of his incapacitated principal, irrespective of the principal's medical condition or prognosis. Such decisions are to be made on the basis of the principal's wishes; or, where the principal's wishes "are not reasonably known and cannot with reasonable diligence be ascertained," on the basis of the principal's "best interests." N.Y. Public Health Law § 2982 (McKinney's 1993). Indeed, the state legislature has been considering proposed new legislation developed by the New York State Task Force on Life and the Law, introduced in the 1995-96 legislative session as S.

5020 / A.6791, which would empower surrogates -- third parties appointed by the *law*, not by the *patient* -- to make decisions under certain medical circumstances to refuse life-sustaining treatment where the patient's "best interests" would be so served. The Second Circuit's equal protection analysis, it would seem, should empower such agents or third party surrogates to ask that the patient be provided with poison as well, so long as they deem it to be in the patient's "best interests."

There is yet one other noteworthy aspect of New York law: the legal obligation of an individual health care provider to carry out the instructions of patients and their duly appointed health care agents; or, if doing so would violate the provider's religious beliefs or sincerely held moral convictions, to cooperate in facilitating transfer of the patient to another medical practitioner who is prepared to carry out such wishes. N.Y. Public Health Law § 2984 (McKinney's 1993). If a doctor has religious beliefs or moral convictions that preclude him from helping the patient commit suicide, would not the Second Circuit's equal protection analysis require his cooperation in transferring the patient to a doctor who has no such qualms?

New York is not atypical in its recognition of a patient's right to decline life-sustaining interventions, either personally or through an agent or surrogate; if anything, New York's common law takes a harder line than most other states in insisting on clear and convincing evidence of an incapacitated patient's wishes. See *Cruzan* v. *Director, Missouri Dept. of Health*, *supra*, 497 U.S. at 270-77. If the Second Circuit's ruling is permitted to stand, its impact will be widespread, profound -- and, in our view, devastating.

III.

ASSIGNING DIMINISHED LEGAL PROTECTION TO A LIFE OF DIMINISHED MEDICAL QUALITY FOLLOWS DANGEROUS HISTORICAL PRECEDENT

In evaluating the state's interest in preserving and protecting a person's life, the Ninth Circuit determined that the strength of the interest depends, in part, on the person's medical condition; when the person is terminally ill and wants to die, the strength of the state interest is low. 79 F.3d at 837. Similarly, the Second Circuit concluded -- unnecessarily for its equal protection analysis, as elaborated *supra* -- that the state's interest in preserving life "lessens as the potential for life diminishes." 80 F.3d at 729. In so doing, the courts below all but nullified this Court's observation that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life." *Cruzan, supra*, 497 U.S. at 282.

Historical precedent confirms the wisdom of allowing society to treat human life, whatever its medical "quality", as an inherent good that deserves state protection. One need look no further than the contemporary example of the Netherlands, where many physicians have apparently engaged in nonvoluntary euthanasia despite that nation's limited authorization of only voluntary euthanasia. The New York State Task Force on Life and the Law described this "abuse" as "an inevitable byproduct of the transition from policy to practice" of permitting the taking of human life "as a 'therapeutic' alternative." *When Death Is Sought, supra*, at 133-34.

The history of the German euthanasia program earlier this century, under which some 200,000 mentally ill or physically disabled people were put to death by German doctors, *see generally* M. Burleigh, *Death and Deliverance: 'Euthanasia' in Germany 1900-45* (Cambridge Press 1994), also bears consideration. Burleigh cites Binding and Hoche's 1920 tract *Permission for the Destruction of Life Unworthy of Life* -- "by far the most influential contribution to the debate on euthanasia" -- as being premised on "the idea that every individual had sovereign powers to dispose of his or her own life as he or she saw fit; specifically to commit suicide." Upon that foundation the authors constructed a model that would lead to widespread medical killing in the name of mercy and social utilitarianism. *Death and Deliverance, supra* at 15-17.

In 1949, Dr. Leo Alexander, chief medical consultant to the prosecution at the Nuremberg War Crimes Tribunal, offered this trenchantly chilling analysis of the origins of the euthanasia program in Germany:

> "Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass

> the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was the attitude toward the nonrehabilitable sick."

Alexander, *Medical Science Under Dictatorship*, 241, New England Journal of Medicine 40, 46 (1949). Dr. Alexander sounded a warning to his fellow Americans:

> "American physicians are still far from the point of thinking of killing centers, but they have arrived at a danger point of thinking, at which likelihood of full rehabilitation is considered a factor that should determine the amount of time, effort and cost to be devoted to a particular type of patient....Americans should remember that the enormity of a euthanasia movement is present in their own midst." *Id.*

We do not mean to suggest that constitutionalizing a right to assisted suicide is likely to lead to the type of moral collapse that occurred in the German medical profession earlier this century. As two commentators have noted, however, we dare not ignore the lessons of that dark era:

> "We have witnessed too much history to disregard how easily a society may disvalue the lives of the 'unproductive.' The 'angel of mercy' can become the fanatic, bringing the 'comfort' of death to some who do not

> clearly want it, then to others who 'would really be better off dead,' and finally, to classes of 'undesirable persons,' which might include the terminally ill, the permanently unconscious, the severely senile, the pleasantly senile, the retarded, the incurably or chronically ill, and perhaps, the aged. . . . In the current environment, it may well prove convenient - and all too easy - to move from recognition of an individual's 'right to die' (to us, an unfortunate phrasing in the first instance) to a climate enforcing a 'duty to die.'"

Siegler & Weisbard, *Against the Emerging Stream: Should Fluids and Nutritional Support be Discontinued?*, 145 Archives of Internal Medicine 130-31 (1985). Yet another commentator issued this bleak observation:

> 'What makes the administrative mass killings so outstanding is not their numbers, their efficiency, or their cruelty, but the fact that they occurred in an epoch when nobody thought it was humanly or socially possible. Therein lies their deepest lesson. If it was possible then, why not again? What has fundamentally changed? The curtain may have gone down -- but only for the intermission." F. Wertham, *The German Euthanasia Program* 31 (1980).

In the decisions below, we detect -- ever so faintly, ever so benignly, but ever so ominously -- the rustling of the curtain once again.

CONCLUSION

The constitution can be a powerful engine of social change -- for better, and for worse. As Agudath Israel sees it, the rulings of the Ninth and Second Circuits are examples of constitutionalism at its most dangerous.

For the reasons set forth in petitioners' briefs, and the additional reasons set forth herein, Agudath Israel of America respectfully urges the Court to reverse the rulings below and clarify the limits of constitutional moral revolution.

Respectfully submitted,

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In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, and CHRISTINE GREGOIRE, Attorney General of the State of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writ Of Certiorari To The United States Courts Of Appeals For The Second And Ninth Circuits

BRIEF OF *AMICI CURIAE* CHRISTIAN LEGAL SOCIETY, CHRISTIAN MEDICAL AND DENTAL SOCIETY, CHRISTIAN PHARMACISTS FELLOWSHIP INTERNATIONAL, NURSES CHRISTIAN FELLOWSHIP, AND FELLOWSHIP OF CHRISTIAN PHYSICIAN ASSISTANTS IN SUPPORT OF PETITIONERS

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41 PP

TABLE OF CONTENTS

Page

Table of Contents i

Table of Authorities iii

Interest of the *Amici Curiae* 1

Summary of Argument 1

Argument 4

I. Physician-Assisted Suicide Will Profoundly Affect the Ability to Obtain and Retain Employment For Health Care Professionals Who Have Religious Convictions Against the Intentional Killing of Oneself or Other Human Beings 4

A. Contrary to the Decisions Below, Health Care Professionals with Religious Convictions Against Killing Other Persons Will Not Be Able to Avoid the Widespread Effects on the Health Care System of Physician-Assisted Suicide 4

B. The Courts Below Failed to Adequately Consider the Rights of Conscience of Medical Care Professionals 14

II. The Second Circuit Wrongly Equated Terminating Life-Sustaining Medical Treatment with Prescribing Lethal Medication in Establishing an Equal Protection Right to Assisted Suicide 18

A. Physicians and Medical Ethicists Today Distinguish Between Hastening Death and Allowing to Die 19

B. The Second Circuit Gave an Inadequate Basis for Equating Physician-Assisted Suicide With the Right to Refuse Treatment .. 21

TABLE OF CONTENTS – Continued

Page

III. The Ninth Circuit Wrongly Characterized the Early Historic Opposition to Suicide Within the Christian Tradition in Establishing a Due Process Right to Assisted Suicide..... 22

A. Contrary to the Suggestion of the Ninth Circuit, Early Christians Firmly Repudiated Suicide..... 23

B. The History and Tradition of the Nation and the State of Washington Firmly Oppose Any Right to Assisted Suicide 28

Conclusion 30

Appendix.....App. 1

TABLE OF AUTHORITIES

Page

CASES

Bowers v. Hardwick, 478 U.S. 186 (1986)..... 23

Brophy v. New England Sinai Hospital, 497 N.E.2d 626 (Mass. 1986)..... 15

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Gary v. Romeo, 697 F. Supp. 580 (D.R.I. 1988)..... 10

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Hobbins v. Attorney General, 518 N.W.2d 487 (Mich. App. 1994) 20

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TABLE OF AUTHORITIES – Continued

Page

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Page

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Page

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Page

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INTEREST OF THE *AMICI CURIAE*

The interest of each *amicus curiae* is set forth in the Appendix to this brief. The letters from the parties consenting to the filing of this brief have been filed with the Clerk of the Court.

SUMMARY OF ARGUMENT

In the rush to divine a new constitutional right to physician-assisted suicide, the courts below failed to give adequate consideration to the consciences of the many health professionals who will be forced to participate in physician-assisted suicide. The decisions below will radically change the health care system into one in which health professionals routinely will be called upon to implement physician-assisted suicide. Many health professionals will find themselves coerced into some degree of involvement in the intentional killing of patients, including patients who are incompetent and not terminally ill.[1]

---

[1] Importantly, the context of "physician-assisted suicide" is not limited to situations in which a competent, terminally ill patient makes his or her own decision to terminate his or her life and seeks from the health care professional "only" the means of doing so. As the Ninth Circuit made clear in *Compassion in Dying v. State of Washington*, 79 F.3d 790 (9th Cir. 1996), its ruling would not be limited to situations in which the patients would self-administer the fatal drug dosage, but would extend as well to patients who are not terminally ill but in a persistent vegetative condition, as well as patients whose guardians make the decision to have a fatal drug dosage administered to the patient. *See, e.g.*, Wash.App. A99 (definition of terminal illness "includes persons who are permanently unconscious, that is in an irreversible coma or a persistent vegetative state"); A100-101 ("recogniz[ing] that in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, or a person acting under his direction or control, may be the only way the patient may be able to receive them"

Amici include health care professionals who have substantial reason to believe that they will be subject to significant pressure from supervisors, insurance companies, employers (including managed care associations, nursing homes, and hospitals) to participate in the administration of fatal drug dosages to patients. *Amici* have religious convictions against enabling others to kill themselves, as well as against killing patients, whether or not the patient has consented to the killing.

Contrary to popular belief, individual physicians on staff at a hospital, health clinic, nursing home, or managed care organization often do not have sufficient autonomy to make medical decisions that carry significant economic costs for their employers. Employers who are concerned about a profitable bottom-line are unlikely to allow employee health professionals the requisite scope to obey their religious convictions, when the employers will be bearing the economic cost of the employees' inconvenient religious convictions. Part I briefly describes a sampling of realistic scenarios in which objecting physicians, medical students, nurses, pharmacists, and other health care professionals will find it virtually

---

but denying that issue was being decided); *id.* n.120 ("Finally, we should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself.").

The court did not address specifically how one person choosing death for another is suicide or how a patient incompetent to make such a decision would be competent to administer the lethal dosage of medicine to herself. Clearly, when the patient cannot self-administer the fatal dosage, someone will be required to do so, and often that person will be the physician or nurse attending the patient.

For purposes of this brief, "Wash.App." will refer to the Appendix to Petition for Writ of Certiorari in *State of Washington v. Glucksberg*, No. 96-110, and "N.Y.App." will refer to the Appendix to Petition for Writ of Certiorari in *Vacco v. Quill*, No. 95-1858.

impossible to avoid participation in physician-assisted suicide. For example, physicians likely will be required to justify, to their employers or insurance companies, a decision not to provide fatal drug dosages to terminally ill patients. Physicians will be asked to provide suicide assistance to patients unable to make such a decision for themselves but whose legal guardian desires a fatal dosage to be administered.

Nor will physician-assisted suicide affect only the patient and doctor. A nurse is likely to be the agent required to administer the fatal dosages, just as he or she is the person who administers most medications to patients in hospitals, clinics, and nursing homes. The ordering physician is unlikely to be sensitive to a nurse's failure to "carry out orders," particularly when the physician is likely to perceive the nurse's refusal as an implicit condemnation of the physician's own morality.

In medical school or residency, medical students may be required to learn, using real patients, how to administer fatal dosages in the proper strength and manner. Medical facilities that refuse to provide such training may be threatened with a loss of accreditation.

The decisions below fail to recognize the legitimate concerns of numerous health professionals who are prohibited by religious convictions from intentionally killing another human being or assisting another person in committing suicide. One effect of the decisions below may be a further decrease in the availability of health care professionals, as many doctors and nurses are driven out of their chosen profession and many students forego medical careers, simply because they cannot participate in a health care system in which physician-assisted suicide is impossible to avoid in real-life terms.

Part II describes the fundamental legal errors in the decisions below. Both courts wrongly equated termination of life-sustaining medical treatment with the affirmative prescription of lethal medication. Yet the common law, numerous state laws, several judicial opinions, and leading medical authorities all recognize that there is a

critical distinction between a decision to stop treatment and a decision to administer deadly drug dosages.

In Part III, *amici* refute the Ninth Circuit's assertion that tradition and history support the right to assisted suicide. Contrary to the Ninth Circuit's interpretation of Biblical accounts of individuals committing suicide, there has been no acceptance of suicide as moral within the historical Christian tradition. Instead, the early Church condemned "self-murder." National and Washington State history also do not support a right to commit suicide.

ARGUMENT

I. Physician-Assisted Suicide Will Profoundly Affect the Ability to Obtain and Retain Employment for Health Care Professionals Who Have Religious Convictions Against the Intentional Killing of Oneself or Other Human Beings.

A. Contrary to the decisions below, health care professionals with religious convictions against killing other persons will not be able to avoid the widespread effects on the health care system of physician-assisted suicide.

At its core, the practice of medicine is based on a relationship – the relationship between the patient and the physician. Both have a moral stance in the relationship, with external and internal pressures acting upon each. The discussion regarding physician-assisted suicide in the decisions below focused almost exclusively on the patient's desires, needs, or rights. However, even if a legitimate case could be made for the need of the patient to be assisted by a physician in committing suicide, it is still necessary to examine the interests and needs of the other party to the relationship – the physician.

Legalizing physician-assisted suicide is certain to affect physicians who object for religious reasons to the intentional termination of another human being's life. For

legal as well as economic reasons, physicians will find it increasingly difficult to refuse to assist patients in committing suicide. Once legalized, the practice of physician-assisted suicide will become the norm, the standard of care expected from a physician. It is likely that a positive duty to perform this "service," and assist patients to commit suicide, will be recognized and become a potential source of malpractice claims against physicians who refuse to perform physician-assisted suicides. Physicians with religious objections to killing oneself or other human beings will be forced either to aid directly in suicide or, at a minimum, to be an accomplice to the suicide by arranging referrals to physicians who are willing to participate. Under some forms of managed care organizations, physicians who refuse to assist a patient in killing himself are likely to be required to pay another physician's charges for killing the patient.

Scenario 1: Dr. Smith is a primary care physician working in a managed care organization. The organization uses a strict capitation model for care, in which patients initially see their primary physician for all complaints and are referred to a specialist only if the primary physician feels it is necessary. The physician must certify the need and authorize the funding for this care. The organization adopts this model of care in order to decrease expenditures for specialty care and realizes a profit only if actual expenditures are less than or equal to those planned for during the term of the contract with the physician. Physicians who repeatedly exceed their "caps" are unlikely to have their contracts renewed.

Dr. Smith evaluates a patient with AIDS, who is still likely to live a considerable length of time but who requests Dr. Smith's assistance in committing suicide now. Dr. Smith considers the likely expenses involved in providing care for this patient if the patient chooses maximal therapy over the next months and years, as opposed to the expenses incurred if the patient commits suicide within the month.

Recognizing that maximal therapy will greatly exceed the cap for this patient, Dr. Smith is nonetheless unable for religious reasons to participate in the suicide herself or to refer the patient to another physician. As a result of this decision, Dr. Smith is likely to face several crises involving coercion of conscience:

1) May her employer, the managed care organization, require her to refer the patient to a physician willing to help him commit suicide?

2) If Dr. Smith is bypassed and someone else in the managed care organization refers the patient to a physician who will assist him in committing suicide, may the employer, the managed care organization, require Dr. Smith to pay for the expenditure for the suicide procedure from her own account?

3) Given that the option for physician-assisted suicide is better financially for the managed care organization, may the organization require its employee Dr. Smith to inform all her HIV-positive patients about the option of physician-assisted suicide?[2]

4) Will Dr. Smith's "mix" of patients change, making her more likely to exceed her overall "cap," with the attending economic consequences for her practice and the likelihood that her contract with her employer will not be renewed?

5) May the managed care organization require Dr. Smith to inform all her patients, even those without lethal illnesses, of the option of physician-assisted suicide, in

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[2] Merely raising the option may suggest to a patient that " 'his or her life was not worth living, a message that would have a powerful effect on the patient's outlook and decision.' " Chairman Charles T. Canady, Subcomm. on the Const. of the House Comm. on the Judiciary, 104th Cong., 2d Sess., *Physician-Assisted Suicide and Euthanasia in the Netherlands* 9 (Comm. Print 1996) (hereinafter "*Physician-Assisted Suicide* Report") (quoting testimony by hearing witness psychiatrist Dr. Herbert Hendin on the prevalence of doctors in the Netherlands who initiate the idea of euthanasia as a treatment option with their patients).

order for them to include the option in their advance written directives?

6) May Dr. Smith be required to record in a patient's records an advance written directive requesting physician-assisted suicide?[3]

Physician-assisted suicide will also harm nurses, medical students, pharmacists, and other health care providers with religious objections to the intentional killing of other human beings. As the following scenarios illustrate, "[n]urses and many other health care workers are particularly vulnerable to pressure because they occupy subordinate positions in the hospital/medical hierarchy." Lynn D. Wardle, *Protecting the Rights of Conscience of Health Care Providers*, 14 J. Legal Med. 177, 220 (1993).

Scenario 2: Nurse Doe is the registered nurse responsible for the medical/surgical floor in a small community hospital. A patient on the floor, who is unable to move or feed himself, requests his physician's assistance in committing suicide. The physician agrees to the patient's request and writes in the patient's chart the order for the patient to be given a lethal dosage of medicine.

Due to her religious convictions, Nurse Doe is opposed to the intentional killing of another human being. Therefore, she informs the physician that she will not administer the lethal dosage of medicine to the patient that the physician has ordered. The physician angrily states that he will administer the drug himself. He

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[3] *Cf.*, The Federal Patient Self-Determination Act, 42 U.S.C.A. § 1395cc(f) (West 1992 & Supp. 1995) (requiring all health care providers receiving Medicaid or Medicare to inform patients about state laws regarding advance directives to refuse life-sustaining treatment and to record any advance directive of the patient). If the decisions below are affirmed, it is not difficult to anticipate that the federal government might require all physicians to record patients' advance directives regarding physician-assisted suicide.

orders Nurse Doe to open the controlled substance cabinet to which she has the key. Nurse Doe is unwilling to assist in the suicide at all.

Nurse Doe faces repercussions for her refusal to participate in the suicide, including:

1) May the physician file a complaint against her for refusing to carry out his orders?

2) May her supervisor take her refusal into consideration in her annual evaluation and in decisions regarding pay raises?

3) Must she abandon hospital nursing in order to avoid similar situations in the future as physician-assisted suicide becomes increasingly widespread?

This scenario is based on the Ninth Circuit's acknowledgment that "in some instances, the patient may be unable to self-administer the drugs and that administration by the physician, *or a person acting under his direction or control*, may be the only way the patient may be able to receive them." Wash.App A100 (emphasis added).

The nurse's role in assisting patients to commit suicide is the subject of the highly instructive *Guidelines for Euthanasia*, promulgated by medical groups in the Netherlands, "in regard to cooperation and job demarcation of doctors/nurses and aids in procedures relating to euthanasia." Royal Netherlands Society for the Promotion of Medicine and Recovery, Interest Association of Nurses and Nursing Aids, *Guidelines for Euthanasia, reprinted in* 3 Issues in Law and Medicine 429 (1988) (Walter Lagerwey trans.). The Guidelines concede that euthanasia has engendered problems between nurses and physicians:

> Lack of clarity in respect to tasks, competences, and responsibilities of doctors on the one hand and nursing personnel and aids on the other, with regard to euthanasia, gives rise to conflicts and dissension in daily practice.

Id. at 429-430.

While claiming that "euthanasia, if it occurs, is performed by a doctor," *id.*, the Guidelines "realize that there

is a discrepancy between the content of these guidelines, in which it is posited that only a doctor shall be entrusted with the carrying out of euthanasia and *actual every day practice in which nursing attendants and aids are often directly involved in euthanasia activities.*" *Id.* at 435 (emphasis added).

The Guidelines recognize that nurses will often receive the initial request for euthanasia. *Id.* at 433. In cases where the doctor has decided to carry out euthanasia, "[i]f the nursing and caring attendant has [sic] doubts about the manner in which the standards of appropriate medical care are carried out," the Guidelines direct the nurse to talk to the doctor. If the nurse still "continues to have serious doubts after receiving information from the doctor," she may consult a second physician or seek the "mediation of the nursing head of the division or directors of the institution," but she must inform both the patient and the attending doctor before she does any of the above. *Id.* at 434-435.[4]

As the primary direct caregivers to patients, nurses necessarily will be the persons most affected by the implementation of assisted suicide in hospitals and nursing homes. They are also the persons least likely to have sufficient influence or authority to be able to avoid complicity in assisting patients to commit suicide. The decisions below will force many nurses into an untenable

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[4] The Guidelines provide that doctors and nurses who have conscientious objections to euthanasia may refuse to participate in the process. But they must also not participate in the *initial* decisionmaking process "because then there can be no question of an objective participation in the decision for euthanasia." *Id.* at 436. That is, an anti-euthanasia physician's participation in the euthanasia decisionmaking process biases the process, but participation by a pro-euthanasia physician does not. If a conscientious objector is the first person to hear the patient's request, "he is (morally) obligated to inform the patient of his view of euthanasia" and "give the patient the opportunity to contact another provider of assistance." *Id.*

position, forcing them either to violate their religious convictions against taking the life of another human being or to forfeit their jobs.

Scenario 3: Dr. Jones has been the physician attending the patients at a small nursing home owned and operated by a religious corporation. The religious tenets of the religious corporation prohibit the intentional taking of human life by oneself or by another. A patient in the nursing home, who has a terminal illness, requests that Dr. Jones assist her in committing suicide. Dr. Jones' religious convictions prohibit both the intentional taking of another human being's life and referral of the patient to a colleague who he knows will assist her in committing suicide.

1) May the patient or her family sue Dr. Jones for refusing to accede to her request for assistance in committing suicide?

2) Must the religious corporation allow physician-assisted suicide for its patients who request it, even though its religious tenets prohibit such conduct?[5]

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[5] Some long-term care facilities have been required by judicial decrees to withdraw feeding and hydration tubes from patients despite the religious or moral objections of the institutions and their employees to withdrawal of life support. *See, e.g., Gary v. Romeo*, 697 F. Supp. 580 (D.R.I. 1988) (hospital ordered to remove feeding/hydration tube of patient in persistent vegetative condition unless patient could be promptly transferred to another facility); *Matter of Jobes*, 529 A.2d 434, 450-451 (N.J. 1987) (private nursing home prohibited from transferring patient to another institution and ordered to withdraw feeding/hydration tube from incompetent patient despite moral opposition of the institution and its employees). *See also*, Wardle, *supra*, at 211-215.

3) Must the physician or the religious corporation transfer the patient to a facility that will perform physician-assisted suicide?[6]

Scenario 4: Pharmacist Johnson is on duty in the only pharmacy in town. He is filling a prescription for a large amount of barbiturates for a patient he knows to have a terminal illness. Because of the quantity and strength of the prescription, Mr. Johnson is reasonably certain that the drug will be used to terminate the patient's life. His religious convictions will not allow him to participate in a suicide. Mr. Johnson faces several issues as he ponders the situation, including:

1) Is it permissible for him to question the patient about the intended use of the prescription?

2) Is it permissible for him to discuss his concerns with the prescribing physician?

3) May the pharmacy owner require the pharmacist to fill the prescription, or would such an order be a

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[6] Defeated by Washington State voters at referendum in 1991, Initiative Measure 119 would have permitted physician-assisted suicide in Washington State. It explicitly stated that objecting physicians would not be criminally or civilly liable if they refused to assist patients in committing suicide. However, it also explicitly required the objecting physician or health care facility to make a good faith effort to transfer the patient to another physician or facility that would terminate his life. Wash.App. H8-9.

The Uniform Health-Care Decisions Act, approved by the National Conference of Commissioners on Uniform State Laws in 1993, requires a health-care provider to comply with an individual's health-care decision unless the provider declines for reasons of conscience. If the provider or institution declines for reasons of conscience, the patient must be promptly informed and the provider or institution must "immediately make all reasonable efforts to assist in the transfer of the patient to another health-care provider or institution that is willing to comply with the instruction or decision." Uniform Health-Care Decisions Act § 7(e)-(g), 9 U.L.A. 220, 239 (1993).

violation of Title VII of the 1964 Civil Rights Act, or applicable state laws, prohibiting discrimination against religious employees?[7]

4) If so, what would constitute a "reasonable accommodation" of the religious employee's refusal to participate in a suicide?

5) If the pharmacy adopts a policy of not filling prescriptions that the pharmacist reasonably believes might be used to commit suicide, will this lack of "service" make it less likely that the pharmacy will be chosen to participate in major health care plans that accept, even promote, physician-assisted suicide as a form of "treatment"?

Scenario 5: St. Mary Hospital is a healthcare and teaching hospital offering medical residency training programs, including programs in geriatrics, oncology, and AIDS treatment. St. Mary adheres to the directives of its sponsoring church, which prohibit the intentional taking of human life, including physician-assisted suicide.

The Accreditation Council for Graduate Medical Education (ACGME) is a nonprofit, private association that evaluates residency programs, based on its own standards. However, the state in which St. Mary Hospital is located bases its accreditation of a hospital entirely upon the recommendation of the ACGME. The ACGME withdraws St. Mary Hospital's accreditation as a teaching hospital, concluding that its programs for training medical residents in geriatrics, oncology, and AIDS treatment are deficient because they do not include actual clinical instruction in physician-assisted suicide.

1) If St. Mary Hospital sues for return of its accreditation, will its claim under the Free Exercise Clause of the

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[7] *See* Wardle, *supra*, at 218 ("[I]n practice, Title VII has provided limited and uneven protection for the rights of conscience of health care workers. Some courts have been grudging in their application of Title VII to health care employees disciplined because of their opposition to abortion.")

First Amendment be outweighed by the ACGME's argument that the government has an overriding interest in providing satisfactory physician education to residents?[8]

2) If St. Mary Hospital loses its accreditation, and thereby loses government funding and reimbursement (since a nonaccredited hospital generally cannot bill for government-funded health care), will it be able to remain open?

3) If medical training programs that refuse to provide actual clinical instruction in the administration of lethal drug dosages to patients are denied accreditation, will medical residents who desire a program in which they are not required to participate in clinical instruction in the administration of lethal dosages to patients be able to find such a program?[9]

If physician-assisted suicide is legalized, it is highly foreseeable that an attempt will be made to condition accreditation for all medical training programs upon the

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[8] The above scenario draws upon an actual case in which a religiously-affiliated hospital lost accreditation for its medical residency training programs in obstetrics-gynecology for a variety of reasons, including its refusal for religious reasons either to provide clinical instruction in abortion or to allow its students to receive such training elsewhere. A federal district court denied the hospital's claim under the free exercise clause to an exemption from the requirements of the ACGME, which the court assumed was a state actor for purposes of licensing medical facilities. The court ruled that the state's interest in "satisfactory physician education" overrode the hospital's religious convictions against providing training in abortion. *St. Agnes Hospital of the City of Baltimore, Inc. v. Riddick*, 748 F. Supp. 319 (D. Md. 1990).

[9] *See* Wardle, *supra*, at 193, 221-222 (medical and nursing students are particularly vulnerable to pressure to participate in procedures to which they have moral or religious objections; students with such objections may be discriminated against in the admissions process or penalized during training, if they will not participate in morally controversial procedures.)

inclusion of clinical instruction in physician-assisted suicide. In 1995, the ACGME sought to impose on all medical training institutions a new accreditation standard requiring abortion training in all obstetrics/gynecological residencies. Diane M. Gianelli, *Legislators Seek to Bypass ACGME Abortion Training Rule*, American Medical News, July 17, 1995, at 1. Initially, the ACGME proposed standard required institutions that opposed abortion to make arrangements for residents who did not object to abortion to learn the procedure at another institution. *Id.* at 22. In response, in 1996, Congress prohibited the federal, state, and local governments from discriminating against a health care professional, a hospital, or a residency program because of the person's or entity's refusal to perform, train in the performance of, or make referrals for training in or performance of abortions. 42 U.S.C. § 245(a)(1) (1996). The law specifically provides that residency programs must be accredited if they meet all criteria for accreditation except for a requirement that it train in the performance of induced abortions. 42 U.S.C. § 245(b)(1) (1996).

B. The Courts Below Failed to Adequately Consider the Rights of Conscience of Medical Care Professionals.

The Ninth Circuit casually addressed the deadly dilemma its decision would force upon many physicians when it wrote:

> Recognizing the right to "assisted-suicide" would not require doctors to do anything contrary to their individual principles. A physician whose moral or religious beliefs would prevent him from assisting a patient to hasten his death would be free to follow the dictates of his conscience.

Wash.App. A96.

The court's assertion is completely unsupported in the opinion itself or in reality. The court leaves not only

physicians, but also less-empowered health professionals, at the mercy of supervisors who have the authority to issue orders that they assist in patients' suicides. Physicians will face increased malpractice litigation as physician-assisted suicide becomes the accepted standard of care for all physicians, even those with religious objections. Nor does the decision protect religiously-affiliated health care facilities from state regulations or private lawsuits requiring such treatment.

Ironically, in its decision, the Ninth Circuit relied heavily on language from *Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992), suggesting that "the most intimate and personal choices" and "choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." Wash.App. A27. If this standard covers ending one's life by assisted suicide, as the Ninth Circuit holds, then it certainly must cover not having to participate in another's suicide. Assisted suicide, by definition, is not a lone act: It requires one or more assistants. No one should be forced to aid in killing, even if that assistance is necessary for persons desiring to kill themselves – as it most certainly will be for many hospital and nursing-home patients.

An analogous dilemma has already arisen in the context of persons seeking to terminate life-sustaining medical treatment. Some courts have been forced to deal with difficult cases where patients or families request the termination of certain life-sustaining treatments at institutions ethically committed not to deliver such treatments. *See, e.g., Brophy v. New England Sinai Hospital*, 497 N.E.2d 626, 639 (Mass. 1986); note 5, *supra*. Other courts have confronted cases arising where nurses or other health-care providers refused on ethical grounds to participate in nontreatment procedures. *See, e.g., Farnam v. Crista Ministries*, 807 P.2d 830 (Wash. App. 1991) (nurse refused to participate in the withdrawal of life-sustaining treatment for an incompetent patient). Such cases will surely multiply when the so-called medical procedure involves actively hastening death rather than allowing death to

occur. Many physicians and medical ethicists see a bright ethical and moral line dividing the two situations, and will refuse to cross that line under any circumstances.[10]

Following the *Farnam* case, Washington state lawmakers added the following provision to Washington's living-will statute:

> No nurse, physician, or other health care practitioner may be required by law or contract in any circumstances to participate in the withholding or withdrawal of life-sustaining treatment if such person objects to so doing. No person may be discriminated against in employment or professional privileges because of the person's . . . refusal to participate in the withholding or withdrawal of life-sustaining treatment.

1992 Wash. Laws, ch. 98, sec. 6. At the very minimum, the court below should have insured similar fundamental protection for the freedom and conscience of all health-care personnel and institutions when it created a right to assisted suicide.[11]

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[10] *See, e.g.*, Willard Gaylin et al., *Doctors Must Not Kill*, 259 JAMA 2139 (1988). *See also*, discussion at pp. 18-21, *infra*.

[11] Drafting, and then passing, comprehensive language that will truly protect health workers' conscience rights will be difficult. As Professor Wardle concluded after surveying the current state and federal "conscience clauses":

> The current patchwork of state and federal conscience clause laws are well-intentioned but obviously and profoundly inadequate. . . . Virtually all are too narrow, cover too few health care providers, in too few situations, are too easily circumvented, and provide inadequate remedies and procedures to be effective. The deficiencies of these statutes have been compounded by the grudging interpretation given such provisions by many courts.

Wardle, *supra*, at 226. Professor Wardle offers a model "Health Care Providers' Rights of Conscience Protection Act." *Id.* at 227.

Protecting the right of health-care institutions, as well as individual practitioners, to refuse to assist patients in committing suicide ensures not only the freedom and conscience of persons working at those institutions, but also shields the freedom and conscience of patients served in them. Opponents of physician-assisted suicide reasonably fear that, if the practice is legalized, then it will lead to cases where patients are put to death without their full and free consent. *See* Yale Kamisar, *Against Assisted Suicide – Even a Very Limited Form*, 72 U. Det. Mercy L. Rev. 735 (1995). Indeed, in the Netherlands, the only country where physician-assisted suicide is openly practiced, many cases have been documented in which involuntary euthanasia has occurred despite rules against it and procedures theoretically designed to prevent its occurrence. *See* Carlos F. Gomez, *Regulating Death: Euthanasia and the Case of the Netherlands*, 104-13 (1991).[12]

If physician-assisted suicide were legalized in the United States, persons needing hospital or nursing-home care would need to be assured the realistic option to choose an institution where that practice could never happen to them, even when they were weakest and unawares. These important concerns underscore the dangers associated with physician-assisted suicide, and why it is reasonable (indeed compelling) for states to outlaw the practice.

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[12] The 1996 report, *Physician Assisted Suicide and Euthanasia in the Netherlands*, to the Subcommittee on the Constitution of the House Committee on the Judiciary, describes one account of a doctor allegedly "terminat[ing] the life of a nun a few days before she otherwise would have died because she was in excruciating pain, but her religious convictions did not permit her to ask for death." *Physician Assisted Suicide* Report, *supra*, at 19. The report concluded that "the doctor had as little respect for the right to self-determination as he had for religious freedom." *Id.*

II. The Second Circuit Wrongly Equated Terminating Life-Sustaining Medical Treatment with Prescribing Lethal Medication in Establishing an Equal Protection Right to Assisted Suicide.

In *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996), the Second Circuit correctly identified "rational basis scrutiny" as the appropriate standard of judicial review under the Equal Protection Clause of the Fourteenth Amendment for statutes outlawing assisting suicide. However, on the crucial issue of equating types of terminally ill persons, the panel wrote that "those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescription drugs." N.Y.App. 29a-30a. Yet the panel's opinion offered no medical, ethical, or historical authority – indeed, no authority of any type other than its own reasoning from prior decisions – for equating the two groups.

The absence of authority here is telling because it involves a central issue in medical ethics. Although some modern medical ethicists and physicians agree with the panel's conclusion,[13] the great weight of authority maintains that there is a fundamental difference between allowing patients to die by withdrawing or withholding medical treatment and hastening death through medical intervention. This distinction dates at least as far back in Western medical tradition as the ancient Hippocratic Oath. Referring to this oath, this Court once observed, "It represents the apex of the development of strict [ethical] concepts in medicine, and its influence endures to this day." *Roe v. Wade*, 410 U.S. 113, 131 (1973). Under the Hippocratic Oath, which is attributed to the 4th century

[13] *See, e.g.*, Marcia Angell, *Euthanasia*, 319 New Eng. J. Med. 1348, 1350 (1988).

B.C. Greek physician Hippocrates, a physician may refrain from treating patients but may never prescribe any "deadly medicine," even if asked.[14]

A. Physicians and Medical Ethicists Today Distinguish Between Hastening Death and Allowing to Die.

The major Anglo-American professional associations of physicians vigorously maintain this distinction today. Thus, for example, the American Medical Association condemns physician-assisted suicide as "contrary to that for which the medical profession stands" while it condones the withdrawal of life-sustaining treatment if it is in accordance with "the decision of the patient and/or his immediate family."[15] The British Medical Association assumed a similar stance in its 1988 *Euthanasia Report*, which concluded, "There is a distinction between an active intervention by a doctor to terminate life and a decision not to prolong life (a nontreatment decision)."[16]

Leading medical ethicists also accept this distinction. For example, the Hastings Center, a prominent national institute for the study of medical ethics, concluded in a

[14] The text of the Hippocratic Oath is widely reprinted, with this quote taken from the Oath as reprinted in Donald D. Millikin, *Oath of Hippocrates*, in 12 Collier's Encyclopedia 137 (1994). For commentary on this distinction, *see* Gaylin et al., *supra*, at 2139.

[15] Quoted from a 1973 resolution of the American Medical Association House of Delegates, reprinted in Thomas D. Sullivan, *Active and Passive Euthanasia: An Impertinent Distinction?*, in *Euthanasia: The Moral Issue* 53, 54 (Robert M. Baird & Stuart E. Rosenbaum, eds. 1989). For reference to a similar position taken by the Judicial Council of the American Medical Association in 1986, see Gaylin et al., *supra*, at 2139.

[16] *Conclusions of a British Medical Association Review of Guidelines on Euthanasia*, in *Euthanasia*, *supra*, at 155.

1987 report that helped shape the right to refuse life-sustaining treatment:

> Some persons who accept this right of patients to decide to forego treatment are concerned nevertheless that the values supporting it, and in particular self-determination, necessarily imply that voluntary euthanasia and assisted suicide are also justified. We disagree. Medical tradition and customary practice distinguish in a broadly accepted fashion between the refusal of medical intervention and intentionally causing death of assisting suicide.

Hastings Center, *Guidelines on the Termination of Life-sustaining Treatment and the Care of the Dying* 129 (1987). Four of America's premier physician-ethicists, Willard Gaylin, Leon R. Kass, Edmund D. Pellegrino, and Mark Siegler, jointly declared on this point, "Generations of physicians and commentators on medical ethics have underscored and held fast to the distinction between ceasing useless treatments (or allowing to die) and active, willful, taking of life." Gaylin et al., *supra*, at 2139. In a statement that utterly undermines the Ninth Circuit's position, these four scholars added, "Neither legal tolerance nor the best bedside manner can ever make medical killings medically ethical." *Id.*[17]

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[17] An exhaustive study of the issue by the official New York State Task Force on Life and the Law reached a similar conclusion in 1994. New York State Task Force on Life and the Law, *When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994). Also in 1994, in the litigation spawned by Dr. Jack Kevorkian's practice of physician-assisted suicide, a Michigan appellate court accepted this distinction in the context of considering the constitutionality of a state law against assisted suicide. *Hobbins v. Attorney General*, 518 N.W.2d 487, 493 (Mich. App. 1994). For a fuller discussion of this distinction in the context of the Washington State statute at issue in the present case, see Edward J. Larson, *Seeking Compassion in Dying: The Washington State Law Against Assisted Suicide*, 18 Seattle U. L. Rev. 509, 516-19 (1995).

Given the overwhelming weight of medical and ethical authority against its position, it is understandable that the decision below does not cite any medical or ethical authority for equating physician-assisted suicide with terminating life-sustaining medical treatment. Physicians and medical ethicists typically view the two situations as fundamentally different.

B. The Second Circuit Gave an Inadequate Basis for Equating Physician-Assisted Suicide With the Right to Refuse Treatment.

The *only* evidence that the panel offered to support its equal-protection holding was the citation of New York State statutory and common law regarding the right of terminally ill persons to refuse life-sustaining treatment. It then quoted Justice Scalia's concurring opinion in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 297 (1990) (Scalia, J., concurring), as authority for dismissing "the action-inaction distinction" as irrelevant, leading to its conclusion that there is no legally meaningful distinction between "ordering the discontinuance of . . . artificial life-sustaining processes" and "writing a prescription to hasten death." *Quill*, N.Y.App. 30a. In both cases, the panel wrote, "The ending of life by these means is nothing more nor less than assisted suicide." *Id.* Justice Scalia's comment, of course, did not address the latter act and, as noted above, mainstream medical and ethical opinion simply does not equate the two actions. As the 1987 Hastings Center report concluded, "a reasonable, if not unambiguous, line can be drawn between foregoing life-sustaining treatment on the one hand, and active euthanasia or assisted suicide on the other." Hastings Center, *supra*, at 6.

The Second Circuit panel ignored this line and wrongly ordered the state to do likewise. Either the distinction between withdrawing life-sustaining treatment and prescribing lethal medication is sufficient to satisfy rational basis scrutiny, or many of America's most

respected medical ethicists and physicians are irrational regarding an issue of central concern to their profession.

III. The Ninth Circuit Wrongly Characterized the Early Historic Opposition to Suicide Within the Christian Tradition in Establishing a Due Process Right to Assisted Suicide.

In *Quill*, the Second Circuit panel set forth the appropriate tests for determining whether a right to assisted suicide constitutes a fundamental liberty under the substantive component of the Due Process Clause of the Fourteenth Amendment. Of course, a right to assisted suicide has no direct textual support in the language of the Constitution. With respect to such claimed rights, the panel observed:

> Rights that have no textual support in the language of the Constitution but qualify for heightened judicial protection include fundamental liberties so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed. . . . " Fundamental liberties also have been described as those that are "deeply rooted in this Nation's history and tradition."

Quill, N.Y. App. 17a (citations omitted).

The Second Circuit panel concluded that neither of these tests were satisfied regarding a right to assisted suicide. "Indeed, the very opposite is true," the panel wrote, adding as follows:

> The Common Law of England, as received by the American colonies, prohibited suicide and attempted suicide. . . . Although neither suicide nor attempted suicide is any longer a crime in the United States, 32 states, including New York, continue to make assisted suicide an offense. . . . Clearly, no 'right' to assisted suicide ever has been recognized in any state in the United States.

Id. at 18a-19a (citations omitted). Based on this historical record, the panel declined the invitation to create a substantive due process right to assisted suicide. In doing so, it quoted the Supreme Court's apt warning, "The Court is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Id.* at 19a, *quoting Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).

The Ninth Circuit did not exercise such reasoned restraint. The majority *en banc* opinion reversed a prior ruling by a three-judge appellate panel that, like the Second Circuit panel, found "that 'a constitutional right to aid in killing oneself' was 'unknown to the past.'" *State of Washington*, Wash.App. A39 (quoting *Compassion in Dying v. State of Washington*, 49 F.3d 586, 591 (9th Cir. 1995)). Responding expressly to this finding, and implicitly to the Second Circuit panel, the *en banc* opinion stated that "our inquiry is not so narrow. Nor is our conclusion so facile. The relevant historical record is far more checkered than the [panel] majority would have us believe." *Id.* In an apparent effort to provide a traditional foundation for a right to assisted suicide, the Ninth Circuit then presented its own view of the relevant history, including the suggestion that early Christians accepted suicide. We leave it to other *amici* to critique the entire history, but wish to correct the record regarding the historic Christian view of suicide.

A. Contrary to the Suggestion of the Ninth Circuit, Early Christians Firmly Repudiated Suicide.

There was no moral acceptance of suicide within the early Christian church. Beth Spring & Ed Larson, *Euthanasia: Spiritual, Medical, and Legal Issues in Terminal Health Care* 105-19 (1988). No recognized historian has documented instances of early Christian church leaders condoning suicide, as that term is commonly understood, the voluntary taking of one's own life. Quite to the contrary,

they uniformly condemned self murder. *See, e.g.*, Robert Barry, *The Development of the Roman Catholic Teachings on Suicide*, 6 Notre Dame J.L., Ethics & Pub. Pol'y 466-468 (1995); Darrel W. Amundsen, *The Significance of Inaccurate History in Legal Considerations of Physician-Assisted Suicide, in Physician-Assisted Suicide: Ethics, Medical Practice, and Public Policy* (R.F. Weir, ed., 1997).

Even the Ninth Circuit opinion recognized that the influential bishop and Christian scholar Augustine (354-430 A.D.) denounced suicide as a "detestable and damnable wickedness" and that thereafter "the Christian view that suicide was in all cases a sin and crime held sway for 1,000 years." *State of Washington*, Wash.App. A43-44. But the court majority suggested that Augustine's opposition turned the Christian Church against a previously tolerated practice. *Id.* Yet the historical record shows consistent Church opposition to suicide from the earliest days. Regarding the pre-Augustinian period, one scholar recently observed:

> The early orthodox Christian church issued few official moral condemnations of suicide, or of any action for that matter, even though the great proportion of early Christian writers condemned deliberate self-killing vigorously. The lack of "official" condemnations of suicide, however, does not mean that the early Church endorsed or permitted it. The early Church produced many theological and moral writings against suicide, and these views later came to be expressed in councillor and juridical documents after Constantine granted legal status to the Church.

Barry, *supra*, at 467 (footnote omitted).

The notable pre-Augustinian moral and theological writings by recognized Church leaders condemning the practice of suicide include ones by Clement of Alexander (ca.155-ca.220 A.D), Tertullian (ca. 160-ca.220 A.D.), Basil of Caesarea (ca.330-379 A.D.), and Jerome (ca.342-419 A.D.), as well as the anonymous "Epistle to Diognetus"

and Clementine "Homilies." *Id.* at 467 n. 101. The great Church leader Justin Martyr (ca.100-165 A.D.) wrote that suicide "will be opposing the will of God."[18] In his *Divine Institutes*, the theologian Lactantius (ca.240-320 A.D.) commented on suicide that "nothing can be more wicked than this."[19] Bishop John Chrysostom (349-407 A.D.) affirmed that "if it is base to destroy others, much more is it to destroy one's self."[20] Milan's noble-born scholar-bishop, Ambrose (ca. 339-397 A.D.), advised "that holy Scripture forbids a Christian to lay hands on himself."[21]

Further evidence for early Christian opposition to suicide is demonstrated by the rapidity with which the practice passed from public tolerance as Christianity spread throughout the Roman world. One of the leading authorities cited by the Ninth Circuit, Thomas Marzen, et al., *Suicide: A Constitutional Right?*, 24 Duq. L. Rev. 1 (1985), notes:

> The gradual dominance of Christianity in the Roman Empire, culminating in the conversion of the Emperor Constantine in the 4th century A.D., worked a transformation in the cultural attitude toward suicide. Imbuing all strata of the Roman world with its spiritual principles, Christianity provided a view of life that was itself inimical to suicide.

Id. at 26. Once common suicide practices, such as disgraced generals falling on their swords, virtually vanished. Barry, *supra*, at 466. The infanticide of unhealthy or

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[18] Justin Martyr, 2 *Apology* 4, in 6 *Fathers of the Church* 123 (1948).

[19] Lactantius, *Divine Institutes* 3.18, in 7 *Ante-Nicene Fathers* 89 (1951).

[20] John Chrysostom, *Commentary on Galatians* 1:4, in 13 *Select Library of Nicene and Post-Nicene Fathers of the Christian Church* 5 (1977).

[21] Ambrose, *Concerning Virgins* 3.7.32, in 10 *Select Library, supra*, 2d ser., 386 (1979).

unwanted children was absolutely proscribed for the first time. Rodney Stark, *Rise Of Christianity* 124 (1996). In deeds as well as words, early Christians rejected suicide and euthanasia.

In contrast to the consistent historical record of early Church opposition to suicide, the Ninth Circuit writes, "The early Christians saw death as an escape from the tribulations of a fallen existence and as the doorway to heaven." Wash.App. A42. Yet the authority cited by the court for this view went on to state that, even though the Bible "contains no explicit prohibition against suicide," nevertheless, "the early Christians incorporated Judaic attitudes and Platonist philosophy which both opposed the practice." Marzen, *supra*, at 26. In particular, the Ninth Circuit cites the early Christian martyrs, who died rather than renounce their faith, as examples of the acceptance of suicide among early Christians, and quotes from a 200-year-old history of the Roman Empire to describe the nature and extent of the practice. Wash.App. A42-43. Yet submitting to forced martyrdom is not equivalent to modern practices of voluntary suicide, and modern scholarship suggests that earlier historians grossly exaggerated both the number of early Christian martyrs and the eagerness with which they met their fate. *See, e.g.*, Stark, *supra*, at 179-184. Indeed, as noted above, one of the most famous early Christian martyrs, Justin, preached and taught against suicide.

The Ninth Circuit also turns to the Bible to support its position. Here too, however, its reliance is misplaced. The court wrote:

> The stories of four suicides are noted in the Old Testament – Samson, Saul, Abimlech [sic], and Achitophel [sic] – and none is treated as an act worthy of censure. In the New Testament, the suicide of Judas Iscariot is not treated as a further sin, rather as an act of repentance.

Wash.App. A42 n. 25. Actually, there are other examples of suicide recorded in the Bible, but many more examples of faithful Jews and Christians resisting the temptation to

commit suicide. *See* Barry, *supra*, at 454-58. Of the five Biblical suicides identified by the Ninth Circuit, all but Samson were persons utterly alienated from God, and Samson died as a captured warrior in an act intended to kill Israel's enemies. *Id.*, at 452-457. Saul attempted to kill himself by falling on his sword, after losing God's favor and losing in battle. However, his fall on his sword left him "in the throes of death," and he begged an Amalekite soldier to kill him. 2 *Samuel* 1:9. The Amalekite "stood over him and killed him, because I knew that after he had fallen he could not survive." 2 *Samuel* 1:10. King David had the Amalekite killed for his killing of Saul. 2 *Samuel* 1:15-16. This would seem to suggest that assisted-suicide was not met with approval, at least by King David. Like Saul, Abimelech also disobeyed God as a leader of Israel: He murdered his 70 brothers and later asked to be killed after suffering a mortal wound. *Judges* 9:54. Ahithophel was a disloyal counselor to David who strangled himself after his treason was discovered. 2 *Samuel* 17:21-23. Judas hanged himself after betraying Christ, which Marzen notes with mock understatement "hardly recommended suicide to the early Christian church." Marzen, *supra*, at 26. These are not models for Christian behavior, and their suicides underscored their depravity. *See, e.g.*, Barry, *supra*, at 456-57. There simply is no Biblical acceptance of suicide.

In claiming an ancient acceptance of suicide, the Ninth Circuit relied on the writings about suicide of Alfred Alvarez and Emile Durkheim. Wash.App. A42. Neither was an historian, however. Alvarez, who wrote in defense of suicide, is a poet who writes of himself that he "began as a literary critic, but by the end of the 1960s had grown weary of writing books about other people's books, so effectively gave up criticism in order to concentrate on his own creative work." Alfred Alvarez, in 33 *Contemporary Authors*, n. ser. 6 (1991). One might suspect his history as being a creative effort. *See, e.g.*, Darrel W. Amundsen, *Did Early Christians "Lust After Death"?* 12 Christian Research J. (Spring, 1996). Durkheim was a

preeminent nineteenth century French sociologist who devised and utilized a broad definition of suicide that included, in his own words, "All cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." Emile Durkheim, *Suicide: A Study in Sociology* 44 (J.A. Spaulding and G. Simpson, trans., 1951). Thus, for Durkheim, suicides included soldiers and martyrs who knowingly gave their lives for political or religious causes – a subjective desire to die was irrelevant. *See id.* at 227. The writings of Alvarez and Durkheim do not provide historical support for early Christian acceptance of the type of suicide at issue in this case.

The Ninth Circuit's attempt at Biblical interpretation illustrates the danger of judicial interpretations of religious doctrine. It is hard to "imagine a subject less amenable to the competence of the federal judiciary, or more deliberately to be avoided where possible." *Lee v. Weisman*, 112 S. Ct. 2649, 2671 (1992) (Souter, J., concurring).

B. The History and Tradition of the Nation and the State of Washington Firmly Oppose Any Right to Assisted Suicide.

The test that the Ninth Circuit apparently is trying to satisfy with its analysis of historical attitudes toward suicide describes fundamental liberties as those that are "deeply rooted in this Nation's history and tradition." *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977). *See Griswold v. Connecticut*, 381 U.S. 479, 506 (1965) (White, J., concurring). By its terms, this test looks only to American history and tradition – which is what the Second Circuit panel did in finding no right to assisted suicide under the Due Process Clause. *Quill*, N.Y.App. 18a-19a. The same result should follow for the Washington State law against assisting suicide at issue in the Ninth Circuit case. If the history and tradition of this statute are any guide, they strongly support upholding it as constitutional.

Restrictions against assisting suicide were in place in Washington even before the region became a state. The second bill passed by the first territorial legislature for Washington, in 1854, provided, "Every person deliberately assisting another in the commission of self-murder, shall be deemed guilty of manslaughter." 1854 Wash. Laws p. 78, § 17. That law or one similar to it has remained on the books in Washington ever since. *See* 1869 Wash. Laws p. 201, § 17; 1873 Wash. Laws, p. 184, § 19; and 1909 Wash. Laws, ch. 249, § 135.

In its present form, the Washington law also reflects the relatively recent influence of the Model Penal Code, which was crafted by the leading criminal law scholars of the mid-twentieth century. Stanford Kadish, *The Model Penal Code's Historical Antecedents*, 19 Rutgers L.J. 521 (1988). The drafters of the Model Penal Code considered the arguments in favor of decriminalizing assisting suicide, but ultimately decided to retain that traditional feature of Anglo-American criminal law. In the commentary to the Code, the drafters noted that "the interests in the sanctity of life that are represented by the criminal homicide law are threatened by one who expresses a willingness to participate in taking the life of another, even though the act may be accomplished with the consent, or at the request, of the suicide victim." American Law Institute, *Model Penal Code and Commentaries*, I, 100 (1985). Indeed, it is difficult to think of a more effective way of discouraging suicide than to stop others from helping the victim.

In the past thirty years, following the publication of the Model Penal Code, eight states passed new statutes specifically outlawing assisted suicide and eleven other states, including Washington in 1975, revised their existing statutes. Marzen, *supra*, at 100. In 1991, Washington State voters rejected an initiative measure that would have legalized physician-assisted suicide.[22] A year later,

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[22] *See* N.Y. Times, Nov. 7, 1991, sec. B, at 16.

the Washington State legislature added a provision expressly excluding physician-assisted suicide from the state's advance-directives statute. 1992 Wash. Laws, ch. 98, sec. 10. In short, the history of the Washington State law against assisting suicide demonstrates an acceptance of such statutory bars that is deeply rooted in both the Nation's and the State's history and tradition.[23]

CONCLUSION

For the above reasons, the decisions below should be reversed.

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[23] For a fuller analysis of the history of the Washington State law against assisting suicide, see Edward J. Larson, *Prescription for Death: A Second Opinion*, 44 DePaul L. Rev. 461, 462-66 (1995).

APPENDIX

INTERESTS OF THE *AMICI*

The **Christian Legal Society** ("CLS"), founded in 1961, is a nonprofit ecumenical professional association of 4,000 Christian attorneys, judges, law professors, and law students with chapters in every state and at 85 law schools. CLS' legal advocacy and information arm, the Center for Law and Religious Freedom, defends religious exercise and the sanctity of human life in state and federal courts at all levels.

The Society is committed to religious liberty because the founding instrument of this nation acknowledges as a "self-evident truth" that all persons are divinely endowed with rights that no government may abridge nor any citizen waive. Declaration Of Independence (1776). Among such inalienable rights are those enumerated in (but not conferred by) the First Amendment, the first and foremost of which being religious liberty. The right sought to be upheld here inheres in all persons by virtue of its endowment by the Creator, Who is acknowledged in the Declaration. It is also a "constitutional right," but only in the sense that it is recognized in and protected by the U.S. Constitution. Because the source of religious liberty, according to our nation's charter, is the Creator, not a constitutional amendment, statute or executive order, it is not merely one of many policy interests to be weighed against others by any of the several branches of state or federal government. Rather, it is foundational to the framers' notion of human freedom. The State has no higher duty than to protect inviolate its full and free exercise. Hence, the unequivocal and non-

negotiable prohibition attached to this, our First Freedom is "Congress shall make **no** law. . . . "

The **Christian Medical and Dental Society** ("CMDS") was founded in 1931 and today represents over 10,500 members – primarily practicing physicians representing the entire range of medical specialties. These members share a common commitment to the principles of biblical faith and the integration of those principles with professional practice. Among other functions, the CMDS Medical Ethics Commission gathers together member experts in the field of medical ethics who formulate positions on vital issues. These positions are subsequently voted upon for adoption, amendment, or rejection by over 100 elected representatives to the national convention of the Society.

CMDS has through this democratic process arrived at a life-honoring consensus among the membership on the issue of physician-assisted suicide. CMDS views this life-honoring principle as essential to protecting the lives and best interests of our patients, practicing medicine conscientiously according to long-standing Hippocratic and religious principles, and preserving the public respect accorded to physicians as guardians of health and life.

The **Nurses Christian Fellowship** was founded in 1948 and is a department of InterVarsity Christian Fellowship. It represents approximately 2000 nurses and publishes *The Journal of Christian Nursing*, which has over 9000 subscribers. The Nurses Christian Fellowship represents nurses who are students and faculty in schools of nursing, and nurses who work in hospitals, long-term care facilities, and health agencies in the community.

The **Christian Pharmacists Fellowship International** (CPFI) was incorporated as a non-profit group of Christian pharmacists in 1984 with the express purpose of promoting the integration of Biblical principles into the global practice of pharmacy. CPFI has 1000 professional members, consisting of those practicing all branches and specialties within the field of pharmacy. The position taken in this brief is consistent with a position paper filed by CPFI, published in the October, 1996 issue of *The Annals Of Pharmacotherapy*.

The **Fellowship of Christian Physician Assistants,** founded in 1980, has 700 member physician assistants. Working with physician supervision in hospitals, long-term care facilities, and clinical settings, physician assistants provide physician services, including highly technical services, in all medical specialties. The members of the Fellowship of Christian Physician Assistants are certain that physician assistants will be routinely delegated the task of carrying out the orders for physician-assisted suicide.

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Nos. 95-1858 and 96-110

In The

Supreme Court of the United States

October Term, 1996

VACCO *et al., Petitioners,* v. QUILL *et al., Respondents.*

WASHINGTON *et al., Petitioners,* v. GLUCKSBERG *et al., Respondents.*

On Writ Of Certiorari To The United States Court Of Appeals For The Second And Ninth Circuits

BRIEF AMICI CURIAE OF THE NATIONAL LEGAL CENTER FOR THE MEDICALLY DEPENDENT & DISABLED, INC., on behalf of its client population; JULIE L. AARDAPPEL, by and through her guardian Gary W. Aardappel; LORRAINE BANKS; JOHN THOMAS "JACK" DOUCETTE, by and through his guardian Margaret Doucette; KATHLEEN LUMBRA; BRUCE W. MATSON and KEITH C. MATSON, by and through their guardians Paul C. and Rosemarie Matson; SALLY BEACH, R.N., individually and on behalf of her terminally ill patients; DR. DAVID L. VASTOLA, D.O., individually and on behalf of his terminally ill patients; DISABILITIES PERSPECTIVES; THE ETHICS AND ADVOCACY TASK FORCE OF THE NURSING HOME ACTION GROUP; AND THE MICHIGAN HANDICAPPER CAUCUS; IN SUPPORT OF PETITIONERS

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37 pp

QUESTION PRESENTED

Your amici adopt the Questions Presented by the Petitioners State of New York and State of Washington.

TABLE OF CONTENTS

QUESTION PRESENTED i

TABLE OF AUTHORITIES iv

INTERESTS OF THE AMICI CURIAE 1

SUMMARY OF THE ARGUMENT 3

ARGUMENT 5

I. INTRODUCTION 5

II. DIMINISHED CONSTITUTIONAL STATUS FOR PERSONS WITH TERMINAL CONDITIONS RESULTS FROM A CONSTRUCTION OF THE FOURTEENTH AMENDMENT THAT MANDATES DISCRIMINATORY EXCLUSION OF SUCH PERSONS FROM THE PROTECTION OF OTHERWISE UNIFORM LAWS BANNING ASSISTED SUICIDE. 5

A. *Incorporation into the Fourteenth Amendment of a Sliding-Scale Rule for Measuring the Worth of Persons to the State Would Be Contrary to Its Purpose and the Precedents of This Court.* 7

B. *Incorporation into the Fourteenth Amendment of a Sliding-Scale Rule for Measuring the Worth of Persons Would Sanction Abuse and State Discrimination.* 12

III. RECOGNITION OF A DUE PROCESS LIBERTY OR EQUAL PROTECTION RIGHT TO ASSISTED SUICIDE WOULD RESULT IN NONVOLUNTARY KILLING OF PERSONS DEEMED TO HAVE A DIMINISHED QUALITY OF LIFE. 16

A. *The Reasoning of the Courts Below Extends Their Holdings to Sanction Nonvoluntary Killing of Persons Deemed to Have an Insufficient Quality of Life.* 16

B. *The Treatment Refusal and Abortion Law On Which The Courts Below Rely Would By Analogy Sanction Administration of Assisted Suicide to Incompetent Persons Without Terminal Conditions.* 18

1. Treatment Refusal Law 18

2. Abortion Law 20

C. *Recognition of a Liberty or Right to Assisted Suicide For Persons With Terminal Conditions Would Irrationally Abolish the Presumption in Anti-Suicide Laws That Suicidal Persons Are Mentally or Emotionally Ill, Resulting in Nonvoluntary Killing of Many Such Persons.* 21

IV. A CONSTRUCTION OF THE FOURTEENTH AMENDMENT THAT MANDATES EXCLUSION OF PERSONS WITH TERMINAL CONDITIONS FROM EQUAL PROTECTION OF STATE LAWS BANNING ASSISTED SUICIDE WOULD VIOLATE CONGRESSIONAL POLICY EXPRESSED THROUGH THE AMERICANS WITH DISABILITIES ACT. 24

CONCLUSION 26

TABLE OF AUTHORITIES

Statutes

29 C.F.R. app. § 1630.2(j) 25

42 U.S.C. § 1396a(w) (1995) 15

42 U.S.C. § 12102 (1995) 25

42 U.S.C. § 12132 (1995) 25

42 U.S.C. § 12201(d) (1995) 26

42 U.S.C. §§ 12132-12182 (1995) 24

Alaska Stat. § 11.81.430(a) (1993) 22

Alaska Stat. § 47.30.700 (1993) 22

Ariz. Rev. Stat. Ann. § 36-533(A)(1) (1993) 22

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Cal. Welf. & Inst. Code § 5201 (West Supp. 1993) 22

Cal. Welf. & Inst. Code § 5213 (West Supp. 1993) 22

D.C. Code § 21-2210 (Michie 1989 & Supp. 1995) 20

Haw. Rev. Stat. § 334-60.2(2) (1993) 22

Haw. Rev. Stat. § 703-308(1) (1993) 22

Idaho Code § 66-317(M) (1994) 22

Idaho Code § 66-324 (1994) 22

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Nev. Rev. Stat. Ann. § 433A.310(1) (Michie Supp. 1993) . 22

Or. Rev. Stat. § 161.209 (1993) 22

Or. Rev. Stat. § 161.209 (1993) 22

Or. Rev. Stat. § 426 (1994) 22

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Bellotti v. Baird, 443 U.S. 622 (1979) 21

Buck v. Bell, 274 U.S. 200 (1927) 11

City of Cleburne v. Cleburne Living Ctr., Inc., 473 U.S. 432 (1984) 10

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) 5, 8, 9, 12, 13, 16, 17, 20

Compassion in Dying v. State of Washington, 850 F.Supp. 1454 (W.D. 1994) 21

Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990) 7, 17

Furman v. Georgia, 408 U.S. 238 (1972) 11

Harris v. McRae, 481 U.S. 297 (1980) 14

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Late Corporation of the Church of Jesus Christ of Latter-Day Saints v. United States, 136 U.S. 1 (1890) 23

Maher v. Roe, 432 U.S. 464 (1977) 14

Palko v. Connecticut, 302 U.S. 319 (1937) 11

Poelker v. Doe, 432 U.S. 519 (1977) 14

Quill v. Vacco, 80 F.3d 716 (2nd. Cir. 1996) .. 5, 8, 9, 12, 13, 16, 17, 20

Reynolds v. United States, 98 U.S. 145 (1878) 23

Romer v. Evans, __ U.S. __, 116 S.Ct. 1620 (1996) 10, 11

United States v. Rutherford, 442 U.S. 544 (1979) 7, 15

State Cases

Bartling v. Superior Court of Los Angeles, 209 Cal. Rptr. 220 (Cal. App. 1984) 20

Bouvia v. Superior Court of Los Angeles, 225 Cal. Rptr. 297 (Cal. App. 1986) 20

Cruzan v. Harmon, 760 S.W.2d 408 (Mo. 1988) (en banc) . 9

DeGrella v. Elston, 858 S.W.2d 698 (Ky. 1993) 18

Donaldson v. Van de Kamp, 4 Cal. Rptr. 2d 59 (Cal. App. 1992) 22, 23

Fosmire v. Nicoleau, 75 N.Y.2d 218, 551 N.E.2d 77 (1990) . 9

In re Caulk, 480 A.2d 93 (N.H. 1984) 23

In re Colyer, 99 Wash. 2d 114, 660 P.2d 738, 744 (1983) .. 18

In re Colyer, 660 P.2d 738 (1983) 20

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In re Grant, 109 Wash. 2d 545, 747 P.2d 445 (1987), *modified*, 757 P.2d 534 (1988). 18

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In re Holden, 450 N.Y.S.2d 623 (1982) 23

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In re Storar, 52 N.Y.S.2d 363, 420 N.E.2d 64 (N.Y. 1981) . 13

In re Storer, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981) 17

In re Westchester County Medical Ctr. (O'Connor), 72 N.Y.2d 517, 531 N.E.2d 607 (1988) 9

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County Dec. 13, 1993) (per Kaufman, J.) 11

Rasmussen v. Fleming, 741 P.2d 674 (Ariz. 1987) 20, 23

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4 W. Blackstone, *Commentaries* *189 10

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Treatment, Not Rational Suicide, 4 J. Clin. Ethics 334 (1993)23

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Yale Kamisar, *The "Right to Die": On Drawing (And Erasing) Lines*, 35 Duquesne L. Rev. 481 (1996) (Special Issue) .. 12

Miscellaneous

142 Cong. Rec. S11,169; S11,175-77 (daily ed. Sept. 24, 1996) 15

142 Cong. Rec.H11,047 (daily ed. Sept. 24, 1996) 15

H.R. 4149 and S.2108 ("Assisted Suicide Funding Restriction Act of 1996") 14

Shakespeare, *MacBeth* 9

INTERESTS OF THE AMICI CURIAE

Your amici include persons with terminal conditions or other severe disabilities, and health care professionals or organizations that serve or represent such persons. Your amici have represented or have been amici or proposed intervenors in *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996); *Hobbins v. Attorney Gen. of Mich. (People v. Kevorkian)*, 447 Mich. 436, 527 N.W.2d 714 (1994), *cert. denied*, 131 L. Ed. 2d 723 (1995); *Lee v. Oregon*, Nos. 95-35804, -35805, -35854, -35948, -35949 (9th Cir. filed August 7, 1995) (decision pending); or *McIver v. Krischer*, No. CL-96-1504-AF (Fla. Cir. Ct. Palm Beach County filed Feb. 16, 1996) (challenging Florida's criminal ban against assisted suicide on state and federal constitutional grounds).

The National Legal Center for the Medically Dependent and Disabled, Inc., is a not-for-profit, public interest law firm chartered to represent and defend the rights and interests of persons who are critically or terminally ill, severely disabled, or otherwise medically dependent. The outcome of these cases will directly affect the rights and interests of the National Legal Center's client population.

Disability Perspectives is a California-based, national organization of persons with disabilities. Many of its members have disabilities that would result in death without medical treatment, and a majority of these members are indigent. Disabilities Perspectives works to protect persons with disabilities from abuse by caregivers and to improve the quality of life for persons with disabilities.

The Michigan Handicapper Caucus is a disability rights organization that advocates on behalf of its members and other persons with disabilities. The majority of the Caucus' members have disabilities, many of which are terminal, and are indigent.

The Ethics and Advocacy Task Force is a committee of the Nursing Home Action Group, a non-profit Minnesota-

based corporation with membership throughout the United States. The majority of its membership have disabilities, many of which are terminal, and are indigent. The Group advocates for disability rights, with a particular focus on persons with disabilities who are under guardianship and those residing in long-term care facilities.

Several individual amici have terminal conditions: Lorraine Banks (malignant breast cancer), John Thomas "Jack" Doucette (insulin-dependent diabetes), and Kathleen Lumbra (primary biliary cirrhosis of the liver). Several of your individual amici have severe disabilities and are under guardianship: Julie L. Aardappel, John Thomas "Jack" Doucette, Bruce W. Matson, and Keith C. Matson. These individuals or their guardians know that if assisted suicide for persons with terminal conditions is constitutionalized, then they and other similarly situated persons would be exposed to having assisted suicide requested or ordered for those of them who are or become incompetent. In addition, those not under guardianship — all of whom have a history of depression — know that in a future depressive episode, they will be in danger of being provided assisted suicide rather than suicide prevention services.

Dr. David L. Vastola, D.O., and Sally Beach, R.N. provide health care services to persons with terminal conditions and other severe disabilities. They know that the lives of many of their patients would be threatened were assisted suicide recognized as a right; although they are conscientiously opposed to assisted suicide, they would be required to participate in the practice if it were held to be a constitutionally protected.

This brief was written with the support of funds provided by the Alliance Defense Fund.

Your amici have obtained consent to file this brief from counsel for all of the parties to this action. Copies of letters of consent are being filed concurrently with this brief.

SUMMARY OF THE ARGUMENT

This brief will explore the jurisprudential and practical legal consequences that necessarily arise from recognition of a constitutionally protected right to assisted suicide. It will demonstrate that persons with terminal conditions would lose rather than gain through establishment of any such right.

The purportedly narrow scope of the right claimed by the lower courts reveals that their holdings are rooted in the proposition that the State can have no legitimate interest in protecting the lives of persons deemed to have a diminished quality of life, such as persons with terminal conditions. Such a jurisprudence necessarily diminishes the constitutional status of these persons and their rights in order to justify their unequal treatment under the law.

Although this Court has held that the State may maintain an unqualified interest in the protection of human life, the lower courts deem this interest, and its corollary interest in the prevention of suicide, illegitimate as applied to persons with terminal conditions. In order to justify this conclusion, the courts below impute to the Fourteenth Amendment a sliding-scale rule by which the state's interest in the protection of human life and in the prevention of suicide diminishes as a person's perceived quality of life declines. Incorporation of such a sliding-scale rule into constitutional jurisprudence reverses the decisions of New York's highest court, transforms the Fourteenth Amendment from a shield that protects human life into a sword that threatens it, and imputes to the Constitution itself the view that certain persons are not worthy of the full protection of law and may be treated unequally.

The boundaries of any category (such as "terminal condition") that defines a constitutionally devalued class of persons in relation to their perceived quality of life are inherently vague and expansive. As a consequence of incorporating a sliding-scale rule into the Fourteenth Amendment, the State would be required to treat devalued persons unequally under

its laws preventing self-murder and would also be permitted to discriminate in many other ways — as in other criminal laws intended to protect life and in social and economic programs necessary to sustain life. In addition, public entities would be compelled to subsidize assisted suicide services if the State chooses to support hospice and other similar services.

Although the lower courts purport to recognize a right to assisted suicide only for competent adults who are terminally ill, any such limitations are illusory. The lower courts explicitly contemplate extension of the right to assisted suicide to incompetent, non-terminal persons. Furthermore, both the refusal of treatment and abortion precedents on which they rely would necessarily require such an extension of the right to incompetent, non-terminal persons. Thus, acceptance of a right to assisted suicide would necessarily sanction nonvoluntary killing of incompetent persons since the right would, by operation of existing law, be imputed to third parties to exercise on behalf of such persons.

For persons with terminal conditions, recognition of a right to assisted suicide would abolish the presumption embodied in suicide prevention laws that suicidal ideation is the product of mental or emotional illness. Abolishing this presumption for the terminally ill is unwarranted by psychological fact and by court precedents. Moreover, abolishing the presumption as to persons with terminal conditions would necessarily permit suicides that are the product of mental or emotional illness rather than competent choice.

Persons with terminal conditions qualify as persons with disabilities under the Americans with Disabilities Act (ADA). Thus, recognition of a right to assisted suicide for such disabled persons would sanction discrimination against them contrary to the policy and plain language of the ADA. Assisted suicide cannot be regarded as a special accommodation or benefit for those with terminal disabilities under the ADA any more than a race-based exception to assisted suicide law would be permissible under constitutional law.

Alternatively, if assisted suicide is recognized as a right for persons with terminal disabilities, then the ADA would require that homicide be allowed for such persons who are unable to kill themselves.

ARGUMENT

I. INTRODUCTION

This brief explores the jurisprudential and legal consequences that necessarily flow from invention of a constitutionally protected right to assisted suicide for persons with terminal conditions or other severe disabilities, such as your amici and those they represent and serve. The courts below assume that assisted suicide would so benefit the terminally ill that any abuse or harm that results would be tolerable — or remedied by legislative initiatives taken under benevolent judicial guidance and oversight. *See Compassion in Dying v. State of Washington*, 79 F.3d 790, 832-834 (9th Cir. 1996) ("*Compassion*"); *Quill v. Vacco*, 80 F.3d 716, 731 (2nd. Cir. 1996) ("*Quill*"). As your amici will show, however, recognition of an assisted suicide right that overrides otherwise uniformly applicable bans would so devalue the constitutional status of persons with terminal conditions that abuse and harm is certain to occur and meaningful regulation would be impossible.

II. DIMINISHED CONSTITUTIONAL STATUS FOR PERSONS WITH TERMINAL CONDITIONS RESULTS FROM A CONSTRUCTION OF THE FOURTEENTH AMENDMENT THAT MANDATES DISCRIMINATORY EXCLUSION OF SUCH PERSONS FROM THE PROTECTION OF OTHERWISE UNIFORM LAWS BANNING ASSISTED SUICIDE.

At the heart of the claim for recognition of a right to assisted suicide lies the question: Does the State have any constitutional basis to deter those who provide others with

the means to kill themselves? In the cases now before this Court, however, the inquiry is reframed as a special pleading: Does the State have any constitutional basis to deter those who provide others with the means to kill themselves *when they are dying anyway*? Thus presented, the inquiry pits the power of the State against the hopelessly ill who merely want help to quickly and efficiently seal their own fates.

Your amici ask instead: On what basis may the Constitution be construed to *exclude* persons with diminished life expectancies from the equal protection of laws that forbid assisted self-murder? Does the Fourteenth Amendment intend that the constitutional status and the right to live of persons hinge on quality-of-life or actuarial status?

Both lower courts recognized that the state's interest in the protection of human life, and the corollary interest in the prevention of suicide, will override a purported fundamental liberty or right to assisted suicide in most cases. Indeed, this invented "liberty" or "right" may hardly be exercised at all — *except* by those among the supposedly small segment of the population that is terminally ill, and then only with the help of a physician.[1] The exercise of no other substantial right or liberty is so narrowly circumscribed. If the abortion liberty were like the assisted suicide right as the lower courts conceive of it, then only women whose lives were threatened by continued pregnancy or some other similarly serious condition could obtain an abortion.

In fact, the reasoning of the lower courts is rooted in the proposition that the State can have no constitutional interest in protecting the lives of certain persons — and does not stem from any firm confidence in the existance of any substantial liberty interest in assisted self-killing. The constitutional value of those with "terminal conditions" is necessarily

[1]A "physician only" rule for assisted suicide absurdly assumes that the Constitution recognizes that the State has an enforceable interest in guaranteeing sure death for certain persons, but no enforceable interest in protecting their lives.

discounted as if they are deemed non-viable: In effect, they are demoted to fetal status and denied full personhood.

The New York and Washington statutes uniformly banning assisted suicide presumably protect against some harm or suggest that some benefit would be lost in their absence. To exclude persons with terminal conditions from the protections they provide assumes, as a matter of constitutional law, that these persons cannot benefit from these laws as others or that whatever harm that might befall them without the protection of these laws is of little or no consequence. Such an assumption lacks any basis in the text of the Fourteenth Amendment and cannot be reconciled with the decisions of this Court.

A. *Incorporation into the Fourteenth Amendment of a Sliding-Scale Rule for Measuring the Worth of Persons to the State Would Be Contrary to Its Purpose and the Precedents of This Court.*

The "State may properly decline to make judgments about the 'quality' of life...and may simply assert an unqualified interest in the preservation of human life." *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 282 (1990). In virtual defiance of this conclusion, however, the lower courts held that the Constitution not merely permits, but *compels* the State to qualify its interest in life so that at least the terminally ill may secure the help of others to kill themselves. Construed in this manner, the Fourteenth Amendment, whether by way of its Due Process or Equal Protection Clause, mandates State *dis*interest in their fates. Constitutional interpretation is thus used to accomplish what this Court refused to permit by way of statutory construction: carving out an exception for the terminally ill in an otherwise uniformly applicable statute. *Cf. United States v. Rutherford*, 442 U.S. 544 (1979) (no exception implied in the federal Food, Drug, and Cosmetics Act for terminally ill cancer patients to secure Laetrile).

Thus, the *Compassion* court held that the "strength" of the state's interest in protection of life is necessarily "dependent on relevant circumstances", including the "medical condition" of the person. *Compassion*, 79 F.3d at 817. According to the court, the state's interest in life must vary since, otherwise, "capital punishment[,]...the draft, as well as the defense budget would be unconstitutional." *Compassion*, 79 F.3d at 817 n. 72. By this the court absurdly suggests that the State must stand aside as terminally ill citizens are exposed to purveyors of lethal drugs as the price to be paid for executing convicted murderers and engaging in foreign war.

Moreover, the *Compassion* court recognizes the force of the state's interest in prevention of suicide, but only when "the senseless loss of life taken prematurely" is involved or when the victim could be "restored to a state of physical and mental well-being." *Compassion*, 79 F.3d at 821, 822. The state's interest in preventing suicide for those "in a debilitated state" is, however, "of comparatively little weight." *Id.* According to the court, the Constitution therefore forbids the State from intervening to protect debilitated people while permitting it to protect others.

In *Quill*, the court denies that the State "can possibly have [an interest] in requiring the prolongation of a life that is all but ended," and continues, "Surely, the state's interest lessens as the potential for life diminishes." *Quill*, 80 F.3d at 729, citing *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976) ("We think that the state interest [in preserving life] weakens and the individual's right to privacy grows as...the prognosis dims.") By imputing to the Constitution a *Quinlan*-type, sliding-scale standard for evaluating the value of persons, the *Quill* court thus imposes on New York a rule that has been specifically rejected by the state's highest court, as this Court held in *Cruzan* that it might do.

The New York Court of Appeals explained that its precedents on declining treatment "considered the patients' physical condition relevant *only* because...[the court was] required

to determine whether those were the circumstances in which the patients intended to decline the medical care. The requirement was imposed by the patient, not the State." *Fosmire v. Nicoleau*, 75 N.Y.2d 218, 229, 551 N.E.2d 77, 82 (1990) (emphasis added). Under New York's rule, patients' life-sustaining treatment may be declined "not because the State consider[s] their lives worthless, but because the State value[s] the right of the individual to decide what type of treatment he or she should receive under particular circumstances." *Id.* In this regard, the *Fosmire* court merely underscored its earlier holding that "no person or court should substitute its judgment as to what would be an acceptable quality of life of another." *In re Westchester County Medical Ctr. (O'Connor)*, 72 N.Y.2d 517, 530, 531 N.E.2d 607, 613 (1988).

The New York rule mirrors Missouri's, which this Court upheld in *Cruzan*, 497 U.S. at 282. The Missouri Supreme Court had rejected a sliding-scale standard, basing its decision instead "on the principle that life is precious and worthy of preservation without regard to its quality." *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988) (en banc). The Missouri court observed, "Were quality of life at issue, persons with all manner of handicaps might find the state seeking to terminate their lives. Instead, the state's interest is in life; that interest is unqualified." *Id.* at 420. The court regarded the claim that a patient will not "recover" from a medical condition as "but a thinly veiled statement that her life in its present form is not worth living. Yet a diminished quality of life does not support a decision to cause death." *Id.* at 422. It specifically repudiated the "reasoning upon which *Quinlan* and cases following it rely.... We have found them wanting and refuse to eat 'on the insane root which takes the reason prisoner'." *Id.* at 413 n.5, *quoting* Shakespeare, *MacBeth*, act 1, sc. 3.

Plainly, therefore, the rationales of both the *Compassion* and the *Quill* courts conflict with this Court's decision in *Cruzan*, where it held that States may decline to adopt a sliding-scale rule. Not only this, but both lower courts in effect

hold that the Fourteenth Amendment *incorporates* such a rule — and, as a consequence, mandates that States must devalue their interest in protection of human life in accord with some sort of "quality of life" assessment. The command of the Constitution that the "State cannot so deem a class of persons a stranger to its laws" (*Romer v. Evans*, __ U.S. __, 116 S.Ct. 1620, 1629 (1996)) becomes a command that it must.

The common law regarded suicide and assisted suicide as offenses "against the king, who hath an interest in preservation of all his subjects." 4 W. Blackstone, *Commentaries* *189. To the contrary, say the lower courts: The Constitution informs the State that it has such an interest in only those citizens who pass some quality-control test.

Such an incredible construction of the Fourteenth Amendment transforms it from a shield that recognizes the substantive worth of the life of each person into a sword that actually threatens the lives of those who fail to pass the test. The Framers of the Amendment, who wrote that "life" may not be deprived without due process, could not have intended such a result. Nor could the Framers have intended that the Amendment in fact requires the State to treat persons *un*-equally by excluding them from full protection of their homicide codes. To impute such a purpose to the Amendment mocks its very origins — intended to assure full legal personhood of the former slaves who were once deemed to lack a requisite "quality" of life.

Adoption of a sliding-scale standard as a constitutional rule would in fact attribute to the Constitution itself the forbidden view that some persons "are not as worthy or deserving as others." *City of Cleburne v. Cleburne Living Ctr., Inc.*, 473 U.S. 432, 440 (1984). It would weave into the very fabric of the Constitution a policy that mandates "permitting the destruction of unworthy life." *See* Karl Binding & Alfred Hoche, *Permitting the Destruction of Unworthy Life* (1920), *reprinted in* 8 Issues in L. & Med. 231 (1992). At the very least, it would return this Court to the discredited jurisprudence of *Buck v. Bell*, 274 U.S. 200 (1927).[2]

The right to live is "the right to have rights." *Furman v. Georgia*, 408 U.S. 238, 290 (1972) (Brennan, J., concurring). As such, "neither liberty nor justice would exist if it were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325 (1937). Yet for some, the lower courts would qualify this right and prevent the State from protecting it for them as it does for others. If the lower courts' reasoning were accepted by this Court, then it might rightly be said of the Constitution itself: "It identifies persons by a single trait" — some quality of life, such as a terminal condition — "then denies them protection across the board", thereby "singling out a certain class of citizens for disfavored legal status or general hardships." *Romer v. Evans*, 116 S. Ct. at 1628.

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[2] In finding a constitutional right to assisted suicide based on the sliding-scale rubric, a Michigan trial court opined:

> Although some cases have suggested that the state interest in preserving life should be blind to the quality of life, a number of cases suggest that the state's interest in preserving life does have a qualitative component.... More to the point is *Buck v. Bell*[, 274 U.S. 200 (1927)]. In that case, the United States Supreme Court upheld a state statue that required the sterilization of certain women. The Court found that the state in that case has a sufficient interest to avoid the creation of certain life because the state concluded the quality of such life was too low and too much of a burden on society to permit. As a result of this decision of the United States Supreme Court, one could fairly ask, if the state is allowed to prevent the creation of life because it deems the resulting quality too low, how can it deprive a person of the right, under certain circumstances, to come to that same conclusion with respect to their own life?

People v. Kevorkian, No. 93-11482, slip op. at 27-28 (Mich. Cir. Ct. Wayne County Dec. 13, 1993) (Kaufman, J.), *quoted in* Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 808 (1994).

B. *Incorporation into the Fourteenth Amendment of a Sliding-Scale Rule for Measuring the Worth of Persons Would Sanction Abuse and State Discrimination.*

In the jurisprudential scheme designed by the *Quill* and *Compassion* courts, the Fourteenth Amendment blinds the State to any harm that might befall those with "terminal conditions" at the hands of suicide assisters. The terminally ill become constitutional semi-persons: free to secure the means to kill themselves with the help of others if they choose, but isolated whether or not they so choose from the protection that the State provides to everyone else. Acceptance of the scheme's core premise — that the Constitution requires the state's interest in the protection of human life to balloon and deflate in tandem with some measure of life's "quality" — would have revolutionary jurisprudential implications and catastrophic personal consequences for many of the most vulnerable among us.

First, the inherent difficulty in defining the nature or scope of any constitutionally cognizable category based on a certain "quality" of life portends confusion, abuse, or both. In the context of the present case, for example, physicians cannot often say with any reasonable medical certainty either that a condition is "terminal" or that a patient will die within a fixed time frame. Joanne Lynn et al., *Defining the "Terminally Ill": Insights from SUPPORT*, 35 Duquesne L. Rev. 311 (1996) (Special Issue). Those with "terminal" conditions may include anyone who will die *without* treatment or care, anyone who will die shortly no matter what is done for them, and the entire range of patients in between. *See* Yale Kamisar, *The "Right to Die": On Drawing (And Erasing) Lines*, 35 Duquesne L. Rev. 481 (1996) (Special Issue); Thomas J. Marzen, *"Out, Out Brief Candle": Constitutionally Prescribed Suicide for the Terminally Ill*, 21 Hastings Const. L.Q. 799, 814-9. If proximity to death is the variable that governs when the interest in protecting life diminishes, then advanced age alone should warrant assisted suicide: When a person's shelf-life has expired, then she or he should be

deemed beyond the constitutional pale. The *Compassion* court implies that "terminal condition" may be defined as any court, legislature, or physician chooses with constitutional impunity. 79 F.3d at 831. Acceptance of the court's suggestion, however, would entail potential devaluation of the lives of persons on the basis of virtually any quality that diminishes one's life-span.

By employing equal protection analysis, the *Quill* court directly linked the definition of "terminal condition" that might be used for the purpose of assisting suicide to definitions used in the law that governs refusal of life-sustaining treatment. The "right" to assisted suicide thus waxes or wanes as state law permits or forbids such treatment to be declined in a particular circumstance. Apart from its statutory law that governs declining treatment in specific ways and circumstances, however, New York generally permits any adult to refuse any form of treatment in any circumstance. *See In re Storar*, 52 N.Y.S.2d 363, 420 N.E.2d 64, 71 (N.Y. 1981), and the cases there cited. Fully consistent application of the *Quill* analysis would thus sanction assisted suicide for any person — unless the common law rule on declining treatment is severely modified. So it turns out that any supposed definitional limitation on the exercise of a "right" to assisted suicide based on New York treatment refusal law is as chimerical as the concept of "terminal condition" standing alone.

Second, even assuming that the nature and scope of some "quality" of life can be defined in a constitutionally cognizable way, other circumstances and conditions may have an equal or greater claim to state "disinterest". Chronic, painful, and seriously but not life-threatening conditions may impose burdens on the individual, the caregiver, or the State significantly greater than any which accompany terminal conditions. On what possible basis may the Constitution require the State to adopt a posture of disinterest toward the assisted suicides of the terminally ill, yet deny those with painful or disabling conditions the same access to purveyors of lethal means?

Moreover, if the State *must* remain disinterested when those who are sick or disabled seek suicide assistance, then it *might* decline to consistently assert its interest in the protection of life for whole other classes and categories of persons. If the lives of dying or disabled people lack sufficient interest to the State as a matter of constitutional law, then the State might reasonably conclude on similar grounds that, for example, the indigent and unemployable should likewise be specially eligible for assisted suicide.

More generally, if the state's interest in the protection of life diminishes as death approaches, then the State would be justified at least in imposing a lesser penalty for murder of terminally ill persons than it does for the murder of others. Likewise, the State would be justified in specifically refusing to fund medical and other necessary services for those with terminal conditions.

On the other hand, the State would be compelled to subsidize assisted suicide services if it chooses to continue to subsidize hospice or other forms of end-of-life health care. This Court has held that a legitimate governmental interest in fetal life was sufficient to justify funding childbirth services, while refusing to fund abortion. *Harris v. McRae*, 481 U.S. 297 (1980). *See also Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977). But the rationale for a right to assisted suicide reflected in both lower court decisions presumes that there can be no legitimate basis to distinguish between decisions to forgo treatment and assisted suicide. Consequently, Congress, the States, and public health care facilities would be compelled to fund and provide assisted suicide services if they continue to fund hospice care or other similar services.[3] Moreover, if assisted suicide were

[3] Your amici note that comprehensive legislation has been introduced in both the U.S. House and Senate for consideration next term that would ban the use of federal funds in any and all federal programs for assisted suicide, euthanasia, or mercy killing. *See* H.R. 4149 and S.2108 ("Assisted Suicide Funding Restriction Act of 1996"). The proposed Act was introduced by Rep. Hall (D. Tex.) with 118 additional original [footnote continued next page]

a treatment "right", then federal law would compel Medicaid and Medicare providers to assure that information on its exercise be disseminated to patients, staff, and the community. *See* 42 U.S.C. § 1395cc(f); 42 U.S.C. § 1396a(w).

In upholding a uniformly applicable federal ban on the distribution of certain drugs, this Court noted that "Congress could reasonably have determined to protect the terminally ill, no less than other patients, from the vast range of panaceas that inventive minds can devise." *United States v. Rutherford*, 442 U.S. at 558. If Congress can ban distribution of a drug purported to cure cancer and preserve life, then surely the States may prohibit distribution of drugs and devices to the terminally ill for the purpose of ending life.

[continued from previous page] co-sponsors in the House; it was introduced by Sen. Ashcroft (R. Mo.) and Sen. Dorgan (D. N.D.) with 17 original co-sponsors in the Senate. 142 Cong. Rec.H11,047 (daily ed. Sept. 24, 1996); 142 Cong. Rec. S11,169; S11,175-77 (daily ed. Sept. 24, 1996). Under the rationales of both the *Quill* and *Compassion* courts, the Act would unconstitutionally discriminate on the basis of the manner chosen to "hasten death" if Congress continues to fund hospice and other similar forms of care.

Neither lower court acknowledged that there is any constitutionally cognizable distinction between assisting in suicide and forgoing life-sustaining treatment or providing pain relief that may shorten life as an unintended consequence. However, the Act specifically distinguishes between these categories:

> Sec. 3. Rule of Construction. Nothing in this Act, or in an amendment made by this Act, shall be construed to create any limitation relating to -- (1) the withholding or withdrawing of medical treatment or medical care; (2) the withholding or withdrawing of nutrition or hydration; (3) abortion; or (4) the use of an item, good, benefit, or service furnished for the purpose of alleviating pain or discomfort, even if such use may increase the risk of death, so long as such item, good, benefit, or service is not also furnished for the purpose of causing, or the purpose of assisting in causing, death, for any reason.

III. RECOGNITION OF A DUE PROCESS LIBERTY OR EQUAL PROTECTION RIGHT TO ASSISTED SUICIDE WOULD RESULT IN NONVOLUNTARY KILLING OF PERSONS DEEMED TO HAVE A DIMINISHED QUALITY OF LIFE.

The courts below purport to restrict the right or liberty they recognize to presently competent, consenting adults with terminal conditions. *Quill*, 80 F.3d at 718; *Compassion*, 79 F.3d at 793-94. Any such limitation is illusory. The reasoning of both courts and the precedents on which they rely dictate that any right to assisted suicide must be recognized for incompetent persons and those without terminal conditions as well. Moreover, persons seeking assisted suicide as a result of mental or emotional illness will not be protected against their self-destructive impulses or provided treatment because their right to assisted suicide will eclipse their need for mental health care.

A. *The Reasoning of the Courts Below Extends Their Holdings to Sanction Nonvoluntary Killing of Persons Deemed to Have an Insufficient Quality of Life.*

In finding a liberty to assisted suicide, the *Compassion* court emphasized that, "[W]e should make it clear that a decision of a duly appointed surrogate decision maker is for all legal purposes the decision of the patient himself." 79 F.3d at 832 n.120. The court thus explicitly expands the boundaries of the assisted suicide liberty to include incompetent persons who will be killed not by their own consent, but by the consent of a third party — whether appointed by the affected person, by a court, or by operation of law. Constitutional immunity would extend to the surrogate's decision as if it were the decision of the affected person.

The *Compassion* court's conclusion in this regard is fully consistent with its construction of this Court's decision in *Cruzan*, which it interpreted as finding a "liberty interest in

hastening death" for incompetent, non-terminally ill persons. *Compassion*, 79 F.3d at 816, 816 n.69. For additional support, the *Compassion* court invoked state statutes that provide formalities to authorize forgoing life-sustaining treatment from incompetent persons both with and without terminal conditions. *Id.* at 831.

Similarly, although the *Quill* court purports to restrict the right to competent, consenting adults, it supports its holding by citing exclusively to cases that involved incompetent persons. 80 F.3d at 727-28, *citing In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, *cert. denied*, 454 U.S. 858 (1981) (involving a never-competent person); *In re Eichner, id.* (decided with *In re Storar*) (involving person who had become incompetent); *Rivers v. Katz*, 67 N.Y.2d 485, 495 N.E.2d 337 (1986) (involving involuntarily committed mental patients); *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261 (1990) (involving person who had become incompetent). Indeed, the core rationale of the *Quill* court — that assisted suicide must be permitted whenever life-sustaining treatment may be forgone — necessarily subsumes provision of assisted suicide to incompetent persons. The New York statutes that sanction forgoing treatment, which the court says the right to assisted suicide must mirror, specifically apply to incompetent patients. *See Quill*, 80 F.3d at 727-28. Moreover, since all persons may refuse life-sustaining treatment under New York law whether or not they are terminal, the *Quill* right to assisted suicide must logically be extended to everyone.

Thus, both lower courts contemplate extension of the right or liberty to assisted suicide to incompetent, non-terminally ill persons. Your amici have no need to resort to a "slippery slope" argument to demonstrate the calamitous consequences that would flow from their rationales, especially for persons with mental disabilities. Simply put, recognition of a constitutional right to "hasten death" under sway of either decision would sanction nonvoluntary killing of incompetent persons in the name of Fourteenth Amendment guarantees.

B. *The Treatment Refusal and Abortion Law On Which The Courts Below Rely Would By Analogy Sanction Administration of Assisted Suicide to Incompetent Persons Without Terminal Conditions.*

The courts below rely on treatment refusal and abortion caselaw as analogous precedent for the right or liberty to assisted suicide. When placed into either of these existing jurisprudential frameworks, assisted suicide must be provided to incompetent persons and persons without terminal conditions.

1. Treatment Refusal Law

State courts have generally ruled that "'[a]n incompetent's right to refuse treatment should be equal to a competent's right to do so.'" *In re Grant*, 109 Wash. 2d 545, 747 P.2d 445, 449 (1987), *modified*, 757 P.2d 534 (1988), *quoting In re Colyer*, 99 Wash. 2d 114, 660 P.2d 738, 744 (1983). They have held that third parties must be permitted to exercise the right to refuse on behalf of incompetent persons. As the Kentucky Supreme Court noted in *DeGrella v. Elston*, 858 S.W.2d 698, 706 (Ky. 1993), "In all but two states, Missouri and New York, even when the court has been unable to precisely determine the express wishes of the patient, it has allowed the patient's family, or the patient's guardian, to exercise substituted judgment as to what the patient would wish."

Authority to refuse life-sustaining treatment for incompetent persons has been variously imputed to guardians, reserved by courts, and provided to a statutory succession of decisionmakers in at least thirty-nine jurisdictions by way of caselaw, statute, or both. *See* Thomas J. Marzen, *et al.*, *"Suicide: A Constitutional Right?" — Reflections Eleven Years Later*, 35 Duquesne L. Rev. 261, 279 n.58 (1996) (Special Issue) (citing to cases and statutes).

These authorities empower a surrogate to make life and

death decisions for a person, although the surrogate was *not* appointed by the person (in contrast to a surrogate appointed through a durable power of attorney for health care). The surrogate's decision may be based on an assessment the patient's "best interest" or through a "substituted judgment" in which the surrogate surmises the wishes of the patient. Both forms of decisionmaking may obviously involve vagaries, subjective elements, and bias that more or less dominate depending on just how much is known or can be adduced about what the person would have wanted if competent. In many, if not most cases, the decision will be based on little more than the surrogate's judgment as to whether the affected person's quality of life merits continued provision of life-sustaining treatment or care. In many or most cases, it certainly cannot be said that the surrogate's decision directly reflects the informed decision that the affected person would have made if able to do so.

When assisted suicide is poured into this body of law, surrogates will be empowered to select this "treatment option" for their wards or principals just as they may presently choose to refuse life-sustaining treatment on their behalf. Nothing in the precedents or plain language of either lower court decision suggests that it could or should be otherwise. Whether the lethal agent is self-administered or administered by another is irrelevant: Providing a lethal drug to an incompetent person to ingest is legally indistinguishable from administering a lethal injection because the victim is unable to consent in either case.

Moreover, exercise of the right to refuse treatment "does not depend upon the nature of the treatment refused or withdrawn; nor is it reserved to those suffering from terminal conditions." *Thor v. Superior Court of Solano*, 5 Cal. 4th 725, 21 Cal. Rptr. 2d 357, 855 P.2d 375, 387 (Cal. 1993) (en banc). If the right or liberty to assisted suicide is deemed equivalent to the right to refuse treatment, then its exercise plainly cannot be limited to circumstances in which a person has a "terminal condition". Nor is the authority of surrogates

generally limited either in caselaw[4] or by statute. For example, the District of Columbia's statute authorizing substituted consent provides that a succession of surrogates "shall be authorized to grant, refuse of withdraw consent on behalf of the patient with respect to the provision of any health-care service, treatment, or procedure..." D.C. Code § 21-2210 (Michie 1989 & Supp. 1995). If assisted suicide is simply to be another sort of "treatment" or "procedure" for incompetent patients, then statutory surrogates would be authorized to choose it for their wards and principals.

Indeed, ordering assisted suicide might be deemed the duty of the surrogate in some circumstances. For example, the Washington Supreme Court in *In re Hamlin*, 102 Wash. 2d 810, 689 P.2d 1372, 1375 (Wa. 1984) (en banc), held that a legal guardian "has the duty" to assert an incompetent ward's "right" to refuse medical intervention when this is deemed to be in the ward's best interests. *See also In re Drabick*, 200 Cal. App. 3d 185, 205, 245 Cal. Rptr. 840, 853, *cert. denied sub nom. Drabick v. Drabick*, 488 U.S. 958 (1988). Since both the *Compassion* and *Quill* courts equate assisted suicide with refusal of treatment, unwilling guardians or other surrogates may likewise be compelled to order assisted suicide for their wards or principles or be removed as decisionmakers for failure to act in their "best interests".

2. Abortion Law

Like treatment refusal, access to abortion cannot be limited to competent, consenting adults. "[E]very pregnant minor is entitled . . . . to receive an independent judicial determination that she is mature enough to consent [to an

---

[4]Thus, the right has been exercised by and behalf of persons with various non-terminal disabilities. *See, e.g., Thor v. Superior Court of Solano*, 855 P.2d 375 (Cal. 1993) (quadriplegia); *In re Colyer*, 660 P.2d 738 (1983) (persistent unconsciousness); *Bartling v. Superior Court of Los Angeles*, 209 Cal. Rptr. 220 (Cal. App. 1984) (various respiratory and other problems); *Bouvia v. Superior Court of Los Angeles*, 225 Cal. Rptr. 297 (Cal. App. 1986) (quadriplegia); *McKay v. Bergstedt*, 801 P.2d 617 (Nev. 1990) (quadriplegia).

abortion] or that an abortion would be in her best interests." *Bellotti v. Baird*, 443 U.S. 622, 649, 651 (1979). Like minors, other incompetent persons have a right to abortion.[5] If the right or liberty to assisted suicide is analogous to the abortion liberty, as the lower courts have held, then it follows that assisted suicide must be provided to immature minors and incompetent adults when it is deemed in their "best interest".

The State may restrict access to abortion when the fetus is viable in order to protect its compelling interest in fetal life at this stage of development. But no similar conflict exists between a right to "hasten one's own death" and a competing state interest in protecting the life of another in the context of assisted suicide. Thus, if assisted suicide is recognized as a right analogous to the abortion liberty, then the logic of abortion precedent would dictate that there could be no limitation based on the medical status, such as "terminal condition", of the person who seeks suicide assistance.

C. *Recognition of a Liberty or Right to Assisted Suicide For Persons With Terminal Conditions Would Irrationally Abolish the Presumption in Anti-Suicide Laws That Suicidal Persons Are Mentally or Emotionally Ill, Resulting in Nonvoluntary Killing of Many Such Persons.*

Laws that warrant suicide intervention and prevention measures now rest on the presumption that "suicide or attempted suicide is an expression of mental illness," and repre-

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[5]*See, e.g., In re Jane A.*, 36 Mass. App. Ct. 236, 629 N.E.2d 1337, 1338 (1994) (authorizing substituted judgment decision of temporary guardian to abort child of ward with mental retardation); *In re Moe*, 31 Mass. App. Ct. 473, 579 N.E.2d 682, 687 (Mass. 1991) (authorizing substituted judgment decision of guardian to abort child of ward with mental retardation, giving weight to preference of ward); *In re Doe*, 533 A.2d 523, 526 (R.I. 1987) (authorizing substituted judgment decision of guardian to abort child of ward with mental retardation over objection of ward's mother).

sents a plea for help and the need for psychiatric treatment. *Donaldson v. Van de Kamp*, 4 Cal. Rptr. 2d 59, 64 (Cal. App. 2 Dist. 1992). This presumption forms the basis of our civil commitment laws[6] and laws allowing the use of nondeadly force to thwart suicide attempts. *See, e.g.*, Alaska Stat. § 11.81.430(a) (1993); Haw. Rev. Stat. § 703-308(1) (1993); Or. Rev. Stat. § 161.209 (1993).

However, a holding that persons with "terminal conditions" have a constitutionally recognized right or liberty to assisted suicide would necessarily abolish the presumption for this class of persons. The State could no more presume that a terminally ill person seeking assisted suicide has a mental or emotional illness than it could presume that a woman seeking an abortion or any person refusing life-sustaining treatment is mentally or emotionally ill because they seek to exercise the right.

As a consequence, many suicidal persons with undiagnosed mental or emotional illnesses would die from preventable suicide. They would not and could not be treated the same as other suicidal persons. Because they propose to exercise a constitutional right, the State could not subject them to evaluation, treatment, civil commitment, or any other form of intervention to prevent suicide without first demonstrating an exceedingly compelling justification. Statutes permitting suicide intervention would be subject to challenge as applied to the terminally ill on the grounds that they burden the exercise of a fundamental right.

Suicidal persons with terminal conditions are, however, clinically indistinguishable from suicidal persons without terminal conditions. "[L]ike other suicidal individuals, patients

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[6]*See, e.g.*, Alaska Stat. § 47.30.700 (1993); Ariz. Rev. Stat. Ann. § 36-533(A)(1) (1993); Cal. Welf. & Inst. Code §§ 5200, 5201, 5213 (West Supp. 1993); Haw. Rev. Stat. § 334-60.2(2) (1993); Idaho Code §§ 66-317(M), 66-324 (1994); Mont. Code Ann. §§ 53-21-102, 53-21-121 (1993); Nev. Rev. Stat. Ann. § 433A.310(1) (Michie Supp. 1993); Or. Rev. Stat. §§ 426.005(1)(d)(A), 426.060(2) (1994); Wash. Rev. Code Ann. § 71.05.010(2) (West 1993).

who desire an early death during a terminal illness are usually suffering from a treatable mental illness, most commonly a depressive condition." Herbert Hendin & Gerald Klerman, *Physician-Assisted Suicide: The Dangers of Legalization*, 150 Am. J. Psychiatry 143, 143 (1993); Tia Powell & Donald B. Kornfeld, *On Promoting Rational Treatment, Not Rational Suicide*, 4 J. Clin. Ethics 334, 334 (1993). Abolition of the presumption of mental or emotional illness for suicidal person with terminal conditions would thus be inconsistent with psychological fact.

It is undisputed that the State has a strong interest in preventing suicide. *Addington v. Texas*, 441 U.S. 418, 427 (1979) ("The state has a legitimate interest under its parens patriae powers in providing care to its citizens who...pose some danger to themselves.") As the Arizona Supreme Court observed, "[I]t would be illogical indeed to suggest that the state's interest in preventing suicide magically disappears only when an individual becomes terminally ill and completes certain paperwork." *Rasmussen v. Fleming*, 741 P.2d at 674, 685 (Ariz. 1987). This Court has observed that the State's interest in suicide prevention prevails even against claims based on the First Amendment's protection of free exercise of religion. *Reynolds v. United States*, 98 U.S. 145, 166 (1878); *Late Corporation of the Church of Jesus Christ of Latter-Day Saints v. United States*, 136 U.S. 1, 49-50 (1890).

Moreover, when persons expressly declare their suicidal intent, the state's interest in the protection of life has been held to be overriding. See *Donaldson*, 4 Cal. Rptr. 2d at 63 (state's interest in preventing suicide "overrides any interest [that person with terminal condition] possesses in ending his life"); *In re Caulk*, 480 A.2d 93, 97 (N.H. 1984) (in view of "specific intent of causing... death..., the State's interest in preserving life and preventing suicide dominates"); *In re Von Holden*, 87 A.D.2d 66, 450 N.Y.S.2d 623, 625-26 (1982) (and the cases there cited) ("It is self-evident that the right to privacy does not include the right to commit suicide... To characterize a person's self-destructive acts as entitled to that Constitutional protection would be ludicrous... The preserva-

tion of life has a high social value in our culture and suicide is deemed a 'grave public wrong'.... [T]he case law of our sister states indicates the universality of that principle.")

IV. A CONSTRUCTION OF THE FOURTEENTH AMENDMENT THAT MANDATES EXCLUSION OF PERSONS WITH TERMINAL CONDITIONS FROM EQUAL PROTECTION OF STATE LAWS BANNING ASSISTED SUICIDE WOULD VIOLATE CONGRESSIONAL POLICY EXPRESSED THROUGH THE AMERICANS WITH DISABILITIES ACT.

A holding by this Court that persons with "terminal conditions" may not, as a matter of constitutional law, be provided equal protection of state assisted suicide bans would conflict with Congressional policy forbidding discrimination by public entities on the basis of disability as expressed through the Americans with Disabilities Act of 1990 ("ADA"). Pub. L. No. 101-336, 104 Stat. 327 (codified at 42 U.S.C. §§ 12101-12213 and 47 U.S.C. § 225, 611). The ADA itself provides that people with disabilities are "a discrete and insular minority" who have "been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness". 42 U.S.C. § 12101(a)(7). In enacting the ADA, "Congress considered disability classifications to be just as serious and just as impermissible as racial categorizations". Timothy M. Cook, *The Americans with Disabilities Act: The Move to Integration*, 64 Temple L. Rev. 393, 434 (1991); *see also* Amy Scott Lowndes, Note, *The Americans with Disabilities Act of 1990: A Congressional Mandate for Heightened Judicial Protection of Disabled Persons*, 44 Fla. L. Rev. 417 (1992) (discrimination on the basis of disability constitutes Congressionally-mandated "suspect classification"). Presumably, this Court would not permit the State to legislate a race-based exclusion to the protection of assisted suicide bans — much less contemplate creating a constitutionally mandated, race-based exclusion to such bans. In light of the ADA, neither should it create an exclusion based on the disability of a "terminal condition".

Under the ADA, a "disability" is any "physical or mental impairment that substantially limits one or more of the major life activities of [an] individual." 42 U.S.C. § 12102; *see also* Interpretive Guidelines on Title I of the ADA, 29 C.F.R. app. § 1630.2(j) (whether limitation is "substantial" is determined by the impairment's nature and degree, its expected or actual duration, and its permanence or long-term impact). Plainly, any genuinely terminal condition thus qualifies as a "disability" under the ADA. *See In re Baby K*, 832 F.Supp. 1022, 1028-1029 (E.D. Va. 1993), *aff'd on other grounds*, 16 F.3d 590 (4th Cir. 1994), *rev. denied sub nom. Baby K v. Ms. H*, __ U.S. __, 115 S. Ct. 91 (1994) (denial of life-sustaining ventilator on the basis of anencephalic disability violates ADA).

The ADA prohibits actions by or policies of public entities that "exclude from participation in" or "deny the benefits of" any program, service, or activity of the public entity or by which persons are "subjected to discrimination by any such entity." 42 U.S.C. § 12132 (1995). As public entities, the States are thus obliged to afford the same treatment to suicidal persons with terminal disabilities as it does to others in its laws and programs. A decision that would compel the State to treat those with terminal conditions differently under its laws and programs intended to protect against or prevent suicide or assisted suicide would thus run counter to the ADA.

If assisted suicide were recognized as a right for competent persons able to commit suicide by themselves, however, then the ADA would require that direct lethal means must be permitted for persons who, due to disabilities, are unable to kill themselves. Otherwise, persons whose disabilities render self-killing impossible would be "exclud[ed] from participation in" and "den[ied] the benefits of" assisted suicide solely because of disability. In sum, the ADA would require that homicide be allowed for otherwise qualified persons who, because of disability, are unable to kill themselves.

The ADA also provides that "[n]othing in this Chapter

shall be construed to require an individual with a disability to accept an accommodation, aid, service, opportunity, or benefit which such individual chooses not to accept." 42 U.S.C. § 12201(d) (1995). Persons with terminal conditions would have no choice but to accept inferior assisted suicide protection and prevention services in a regime inspired by a holding that discounts the state's interest in protection of their lives.

In any case, conflict with the ADA cannot be avoided by claiming that recognition of a right or liberty for the terminally ill would merely present them with a unique "choice" to decline the "benefits" of state suicide prevention and protection policies that is not accorded to others. It might just as easily be claimed that a policy that allowed only members of a certain race to waive equal protection of state assisted suicide bans and suicide prevention programs simply offers to that race the "benefit" or "accommodation" of assisted self-killing. Such a race-based exclusion would plainly be rejected by this Court — just as it should likewise reject the disability-based exclusion that recognition of a constitutional right or liberty to assisted suicide for the terminally ill would create.

The anti-discrimination policy embodied in the ADA would be undermined by any constitutional rule that mandated the State to treat persons with terminal conditions differently than others in assisted suicide and suicide prevention law and policy. A decision recognizing such a rule would, in effect, declare that death is a "benefit" for this class of persons with disabilities, while it remains a harm for all others. It would warrant the "most pernicious discriminatory bias against the disabled that one can imagine...in the name of the disabled's right to die." Laurence H. Tribe, *American Constitutional Law* 1598-1599 (1988).

CONCLUSION

Your amici pray this Court to reverse the decisions of the lower courts and to reject the claim of a constitutionally protected liberty or right to assisted suicide.

Respectfully submitted,

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DENNIS C. VACCO, et al.,

Petitioner,

vs.

TIMOTHY E. QUILL, M.D., et al.,

Respondent.

and

STATE OF WASHINGTON, et al.,

Petitioner,

vs.

HAROLD GLUCKSBERG, M.D., et al.,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Second Circuit And To The United States Court Of Appeals For The Ninth Circuit

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47pp

TABLE OF CONTENTS

Page

Statement of Interest 1

Summary of Argument 3

Argument 5

I. Preserving the distinction between killing a person and allowing a person to die protects personal liberty; a regime of physician-assisted suicide would not 5

A. The distinction between killing a person and allowing a person to die is well grounded in the common law 5

B. There is no substantive liberty interest in taking one's life, much less in having a physician "assist" in this process 7

C. Misguided reliance upon *Cruzan* 10

D. Misguided reliance upon *Casey* 12

E. The Impossibility of Establishing Reliable Criteria for Limiting Physician-Assisted Suicide 13

F. Legitimate Governmental Interests in Prohibiting Physician-Assisted Suicide 19

(1) Protecting the role of physicians as healers, not killers 21

(2) Preventing the abuse of widespread involuntary euthanasia 22

II. Preserving the distinction between killing a person and allowing a person to die promotes the equal dignity of all persons; a regime of physician-assisted suicide would not 24

TABLE OF CONTENTS – Continued

Page

A. Protecting the elderly infirm from the grave risk of involuntary euthanasia 25

B. Protecting the poor and minorities from the grave risk of involuntary euthanasia..... 27

C. Protecting persons with disabilities from the grave risk of involuntary euthanasia..... 28

Conclusion 29

TABLE OF AUTHORITIES

Page

CASES CITED:

Barber v. Superior Court, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983) 6

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Browning v. Herbert, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989), *aff'd*, 568 So. 2d 4 (Fla. 1990)..... 16

Califano v. Aznavorian, 439 U.S. 170 (1978)..... 25

Cantwell v. Connecticut, 310 U.S. 696 (1940)..... 7

City of Cleburne v. Cleburne Living Center, 473 U.S. 432 (1985)..... 29

Collins v. City of Harker Heights, 503 U.S. 115 (1992) 10

Cruzan v. Director of Missouri Department of Health, 497 U.S. 261 (1990).....10, 11

Gitlow v. New York, 268 U.S. 652 (1925)..... 7

Harris v. McRae, 448 U.S. 297 (1980) 11

Kramer v. Union Free School Dist. No. 15, 395 U.S. 621 (1969)..... 27

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TABLE OF AUTHORITIES – Continued

Page

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Palko v. Connecticut, 302 U.S. 319 (1937) 9

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People v. Kevorkian, 534 N.W. 2d 172 (Mich. App. 1995) 16, 17

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Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992) 12, 13, 16

Poelker v. Doe, 432 U.S. 519 (1977) 11

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Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 105 N.E. 92 (1914) 6

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TABLE OF AUTHORITIES – Continued

Page

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U.S. Const. Amend. XV 25

U.S. Const. Amend. XIX 26

U.S. Const. Amend. XXIV 27

STATUTORY PROVISIONS CITED:

29 U.S.C. §§ 621 et seq 26

29 U.S.C. § 794 28

42 U.S.C. § 1973 27

42 U.S.C. § 2000a (Title II of Civil Rights Act of 1964) 26

42 U.S.C. § 2000e (Title VII of Civil Rights Act of 1964) 26

42 U.S.C. §§ 3601 et seq. (Title VIII of Civil Rights Act of 1968) 26

42 U.S.C. § 6001 28

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TABLE OF AUTHORITIES – Continued

Page

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Page

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TABLE OF AUTHORITIES – Continued

Page

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Lawrence H. Tribe, *American Constitutional Law* (2d ed. 1988) 11

STATEMENT OF INTEREST

The Evangelical Lutheran Church in America [ELCA] is the largest Lutheran denomination in North America and the fifth largest Protestant body in the United States. It has approximately 11,000 member congregations which in turn have approximately 5.2 million members. As part of its mission, the ELCA supports twenty-eight colleges, eight theological seminaries, 400 missionaries in 50 countries, 450 chaplains in the armed forces, and 260 social service institutions, including hospitals, hospices, long-term care and residential facilities for older persons, and facilities for adults, youth and children with special needs.

The ELCA began its official existence January 1, 1988, as a merger of three predecessor bodies: The Lutheran Church in America [LCA], the American Lutheran Church [ALC] and the Association of Evangelical Lutheran Churches [AELC]. These groups trace their history in this country to the seventeenth century and in Europe to the Reformation in Germany. For deeply religious reasons, Lutherans view the human condition as flawed and broken, sustained only by the grace of God. In a century marked with wars, racism, genocide and other massive evil, secular decision-makers have ample evidence to distrust the rosy picture of inherent human goodness and generous human compassion offered as the predicates for the decisions below.

The guiding principles for specific positions of the ELCA on issues of social ethics are contained in its own social statements and in those of its predecessor church bodies. Task force reports support these statements and messages draw out their implications. Three such documents are directly relevant to the issues discussed in this brief: the 1992 Message of the ELCA on End-of-Life Decisions, a 1982 Social Statement on Death and Dying adopted by the Eleventh Biennial Convention of the LCA, and a paper issued in 1977 by the ALC's Task Force on Ethical Issues in Human Medicine.

The 1992 ELCA Message, appended to the brief as Appendix A, states: "The integrity of the physician-patient

relationship is rooted in trust that physicians will act to preserve the life and health of the patient. Physicians and other health care professionals also have responsibility to relieve suffering. This responsibility includes the aggressive management of pain, even when it may result in an earlier death. However, the deliberate action of a physician to take the life of a patient, even when this is the patient's wish, is a different matter. . . . We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased." App. 5-6.

The 1982 LCA Social Statement states: "Deliberately administering a lethal drug in order to kill the patient, or otherwise taking steps to cause death, is quite a different matter [from refusing treatment]. This is frequently called 'active euthanasia' or 'mercy killing' (as contrasted with . . . withholding or withdrawing medical treatment, thereby allowing death to occur from a disease or injury). Some might maintain that active euthanasia can represent an appropriate course of action if motivated by the desire to end suffering. Christian stewardship of life, however, mandates treasuring and preserving the life which God has given, be it our own life or the life of some other person. This view is supported by the affirmation that meaning and hope are possible in all of life's situations, even those involving great suffering. To depart from this view by performing active euthanasia, thereby deliberately destroying life created in the image of God, is contrary to Christian conscience. Whatever the circumstances, it must be remembered that the Christian commitment to caring community mandates reaching out to those in distress and sharing hope and meaning in life which elicit a renewed commitment to living."

The 1977 ALC paper states: "We affirm that direct intervention to aid the irremediably deteriorating and hopelessly

ill person to a swifter death is wrong. While direct intervention in many cases may appear 'humane,' deliberate injection of drugs or other means of terminating life are acts of intentional homicide. This deliberate act is far removed from decisions which allow people to die – like shutting off a life-support machine or even withholding medication. Permission for the normal process of death is an act of omission in the spirit of kindness and love within the limits of Christian charity and legal concerns. Direct intervention to cause death, known as active euthanasia, can not be permitted. We affirm there is a distinct moral difference between killing and allowing to die."

Letters from the parties consenting to the filing of this brief have been filed with the Clerk of this Court pursuant to Rule 37.3.

SUMMARY OF ARGUMENT

The homicide laws in all of the states prohibit the purposeful, knowing, reckless or negligent killing of another human being. About two-thirds of the states also expressly prohibit assisting or aiding suicide. All of these criminal bans refuse to recognize the consent of the victim as a defense. The two lower courts reviewed in these cases have ruled that the federal constitution *requires* the States to abandon this effort to surround human life at a most vulnerable point with that protection.

The lower courts offer a naively optimistic promise that a regime of physician-assisted suicide would protect the values of liberty and equality. The Ninth Circuit found a liberty interest in the Due Process Clause of the Fourteenth Amendment that would nullify a Washington statute prohibiting physician-assisted suicide. The methodology of substantive due process is ill-suited for grounding a constitutional right to suicide, let alone a right to involve the medical profession in administering lethal poison to kill another person. The Due Process Clause has been used to require that all states protect substantive liberties such as free exercise of religion, freedom

of speech, and freedom of the press. It has never been used to allow the direct intentional killing of another or providing the means of ending life to another person. The Court should not invoke substantive due process to repudiate the constant teaching of the common law that the human person is free to refuse medical treatment, but that a State may reasonably prohibit all persons, including physicians, from acting affirmatively to end human life. The line we insist should be maintained between killing a person and allowing a person to die might not always be perfectly clear, but over a long period of time it has been vastly more effective at preventing abuse than the slippery standards offered by the Ninth Circuit. A regime of physician-assisted suicide would actually exalt physician control over patients and would thus radically undermine personal freedom.

The Second Circuit nullified a similar New York statute as a violation of the Equal Protection Clause. There is no fundamental right to take one's own life, let alone a right to assistance by a physician in ending one's life. Hence New York has a rational basis for maintaining its prohibition of physician-assisted suicide. New York recently completed a lengthy and exhaustive study culminating in a comprehensive report unanimously rejecting the adoption of physician-assisted suicide. The New York report concluded that the regime of physician-assisted suicide in the Netherlands had resulted in massive involuntary euthanasia, and it unanimously repudiated a practice that it legitimately equated with radical undermining of its commitment to equality of all persons, especially older persons, the poor, and those with disabilities. A state is entitled to considerable deference in choosing among policy alternatives. That traditional deference is heightened where the state is acting to fulfill its solemn duty to protect life and to express special concern for the most vulnerable among us.

Both lower courts trivialize the enormous complexity of the issues underlying the social experiment they find imbedded in the Fourteenth Amendment. They make unfulfillable

promises, and they grossly underestimate the peril to liberty and equality inherent in a scheme of physician-assisted suicide.

ARGUMENT

I. Preserving the distinction between killing a person and allowing a person to die protects personal liberty; a regime of physician-assisted suicide does not.

A. The distinction between killing a person and allowing a person to die is well grounded in the common law.

These cases implicate the deepest philosophical concerns about the nature and destiny of the human person. The traditions of this nation have for centuries preserved a delicate balance between individual responsibility and the communal dimension of human life. Each of us is precious and unique, born into communities that support us and shape our very existence: families, religious communities, neighborhoods, cities, states, and the nation itself. By radically transforming the meaning of the fundamental values of liberty (Part I) and equality (Part II), these cases threaten to do irreversible damage to that balance between the individual and the community.

For over two millennia physicians have served their patients with an understanding that their duty was to heal and to support human life in all circumstances. *See* Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics* 330 (4th ed. 1994) (citing the Hippocratic Oath, with its promise "to do no harm"). This duty corresponds to a communal concern to protect the health and well-being of the human person.

The common law also preserved a delicate balance between the individual and the community by acknowledging that a competent person can decline medical treatment. See *Mills v. Rogers*, 457 U.S. 291, 294 note 4 (1982); W. Keeton, *Prosser and Keeton on the Law of Torts* § 18, at 116-19 (5th

ed. Supp. 1984). Indeed, physicians committed common-law torts if they did not first obtain their patients' informed consent. While Justice Cardozo was a judge on the New York Court of Appeals, he wrote: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Schloendorff v. Society of New York Hospital*, 211 N.Y. 125, 129-30, 105 N.E. 92, 93 (1914). *See also Natansen v. Kline*, 186 Kan. 393, 350 P. 2d 1093, 1104 (1960); *Mohr v. Williams*, 95 Minn. 261, 104 N.W. 12 (1905). These cases refer to the right to protect the integrity of one's body from intrusion, and not to any purported right to consent to be killed. Under the common law of battery, then, physicians may allow a patient to die by respecting that person's lack of consent to continuing medical treatment. Aiding such a person's death by causing a bodily intrusion, on the other hand, is clearly a tortious battery whether or not the person consents. *Id.*

Similarly, the criminal law of all the states prohibits the killing of another, even where the victim consents. Withdrawing medical treatment, on the other hand, is not killing and therefore not criminal because it is viewed as an omission by the physician where the patient or appropriate surrogate has elected to decline further medical treatment. See, e.g., *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 195 Cal. Rptr. 484 (1983). This distinction is the legal analogue to the ethical teaching of the ELCA referred to above in the statement of interest, concerning the distinction between killing a person, which we view as highly immoral, and letting a person die, which we acknowledge can be ethically permissible, at least under some circumstances.

B. There is no substantive liberty interest in taking one's life, much less in having a physician "assist" in this process.

Against this clear teaching of the common law of torts and crimes, we assess the constitutional provision relied upon by the Ninth Circuit for its conclusion: "No State shall deprive any person of . . . liberty without due process of law. . . . " U.S. Const. Amend. XIV. This clause obviously cannot mean that no state may ever restrict the liberty of any of its citizens. All of the states do that all the time by a variety of regulatory schemes that frequently entail fines or other penalties that amount to deprivations of liberty. The primary safeguard referred to by the Due Process Clause is obviously procedural. But this Court has also relied upon this clause to ensure that all of the states would protect fundamental liberties with at least as much care as is required of the national government.[1]

The extent to which a right might be regarded as immune from state regulation or prescription is not absolute, but may vary according to the nature of the right and the context within which it is asserted. Examples of liberty interests that this Court has protected under the Due Process Clause against state regulation include freedom of speech, *Gitlow v. New York*, 268 U.S. 652 (1925); freedom of the press, *Near v. Minnesota*, 283 U.S. 697 (1931); and freedom of religion, *Cantwell v. Connecticut*, 310 U.S. 696 (1940). As high as these fundamental liberties rank in our constitutional order, *Thomas v. Collins*, 323 U.S. 516, 530 (1945), *West Virginia State Bd. of Educ. v. Barnette*, 319 U.S. 624, 303 (1943), they do not mean that everyone invoking them is automatically guaranteed that he or she is free from the burden of reasonable governmental regulation. This outcome is determined by

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[1] The states are clearly free to surround human liberty with greater protection or more specific safeguards than is required by the federal Bill of Rights. *See, e.g., PruneYard Shopping Center v. Robins*, 447 U.S. 74 (1980).

a careful examination of the factual context within which a right is asserted, and by the adherence of the government to standards governing its own conduct. Despite Justice Black's persistent view in the absolute character of free speech, *The Bill of Rights*, 35 N.Y.U.L.Rev. 865 (1960), this Court has never thought to invalidate the libel laws of all fifty states. Despite the vital significance of a free press in a free and open society, *New York Times v. United States*, 403 U.S. 713 (1971), this Court has never held that this freedom gives the press greater access to governmentally held information than that enjoyed by the general public. *See, e.g., Saxbe v. Washington Post*, 417 U.S. 843 (1974); Stewart, *Or of the Press*, 26 Hastings L. J. 631 (1975). Or, to illustrate the varying content of parental liberty secured under substantive due process, *Pierce v. Society of Sisters*, 268 U.S. 510 (1926), invalidated a provision of the Oregon constitution that required all children to attend schools operated by the government, but *Pierce* emphatically does not mean that the states must abandon their truancy laws. *Meyer v. Nebraska*, 262 U.S. 390 (1923) invalidated a statute prohibiting the teaching of the German language, but *Meyer* does not mean that the states or the thousands of local school districts are required to teach German or otherwise lack broad discretion to regulate the content of the educational curriculum, at least in the schools they operate.

The relative character of rights subsumed under the Due Process Clause is directly relevant, even critical, to the analysis of these cases. The Ninth Circuit explicitly recognized this approach, yet its opinion is a classic example of careless expansion of this Court's treatment of substantive due process. Taken along the natural trajectory of its logic, the approach of the Ninth Circuit would for all practical purposes mean that no State may restrict the liberty of any of its citizens on this matter, including those who are depressed or simply tired of living. This conclusion is clearly at odds with the text of the Due Process Clause and with the history of its interpretation by this Court. Worse yet, this approach would

nullify the sovereign obligation of the several states to protect life, a duty that is demonstrably clear in the text of the same provision: "No state shall deprive any person of *life* . . . without due process of law."[2]

Reflecting considerable restraint, this Court's general standard for reviewing substantive due process claims is deferential to legislative judgments, unless they impinge upon fundamental rights. The Ninth Circuit explicitly acknowledged that the right it sought to protect is not "fundamental" in the sense that it is so "implicit in the concept of ordered liberty" that "neither liberty nor justice would exist if they were sacrificed." *Palko v. Connecticut*, 302 U.S. 319, 325-26 (1937). Curiously, however, the Ninth Circuit concluded that Washington has no legitimate interest in prohibiting physician-assisted suicide.[3]

The Second Circuit expressly rejected the substantive due process claims pressed in these cases, No. 95-1858, Pet.

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[2] This issue is now before the Ninth Circuit in an appeal from the decision of a district court enjoining a provision in the Oregon constitution recently enacted by initiative. *Lee v. Oregon*, 891 F. Supp. 1429 (D. Or. 1995), on appeal sub nom. *Lee v. Harcleroad* (9th Cir. Nos. 95-35804, 95-35805, 95-35854, 95-35948, and 95-35949). The ELCA joined an amicus brief in *Lee* urging that life is an inalienable fundamental right that may not be "waived" by any class of citizens.

[3] The Ninth Circuit formally recognized that "State laws or regulations governing physician-assisted suicide are both necessary and desirable to ensure against errors and abuse, and to protect legitimate state interests." No. 96-110, Pet. App. A-102. But this language is not reliable as a guide to the lower court's own decision, for the court went to great lengths to dismiss every state interest that might justify judicial restraint as illegitimate or irrelevant. *Id.*, A-65 to A-101. Still less is the Ninth Circuit's opinion reliable as a prediction of the likely outcome in a regime of physician-assisted suicide. In the Netherlands the very categories relied upon by the Ninth Circuit as safeguards against abuse – limiting assisted suicide to cases where the patient is competent, voluntarily opts for death, is terminally ill, and is suffering, and limiting the persons who may offer such assistance to doctors – all broke down within years of the relaxation of the legal standards governing the ending of human life. See 22-23 below.

App. 16a-20a, noting that this Court stated in *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986), that it is not "inclined to take a more expansive view of our authority to discover new fundamental rights imbedded in the Due Process Clause." According to the Second Circuit, "[t]he right to assisted suicide finds no cognizable basis in the Constitution's language or design, even in the very limited cases of those who, in the final stages of terminal illness, seek the right to hasten death." No. 95-1858, Pet. App. 19a. The Second Circuit further noted the Court's reluctance "to expand the concept of substantive due process because guideposts for responsible decisionmaking in this uncharted area are scarce and open-ended." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). And the Second Circuit concluded: "Our position in the judicial hierarchy constrains us to be even more reluctant than the Court to undertake an expansive approach in this unchartered area." No. 95-1858, Pet. App. 20a. For the reasons set forth above, we urge the Court not to find a new right to physician-assisted suicide in the Due Process Clause, but to allow the States to maintain a prohibition of physician-assisted suicide and to sustain a distinction – well grounded in the common law of torts and crimes – between killing a person and allowing a person to die.

C. Misguided reliance upon *Cruzan*

The Ninth Circuit relied on *Cruzan v. Director of Missouri Department of Health*, 497 U.S. 261 (1990). No. 96-110, Pet. App. A-58 to A-62. In *Cruzan* this Court considered whether the Fourteenth Amendment protected a liberty interest of a patient to refuse or to terminate medical treatment, even if it meant the patient would die. The Court held that the State could impose a stringent evidentiary standard to prove that an incompetent patient, while competent, had expressed a desire to have life-saving medical treatment terminated. In the process of the decision, a majority of the justices seemed to accept a right of a competent patient to

terminate medical treatment, even though it would clearly hasten death.

The extreme conclusion reached by the Ninth Circuit is not required by the majority opinion in *Cruzan*. Indeed, nowhere in all of the opinions in *Cruzan* did any member of this Court ever intimate the view ascribed to the Court by the Ninth Circuit in this case. *Cruzan* can be read as protecting a right to refuse medical treatment, *see Cruzan*, 497 U.S. at 269-80, or more narrowly as an evidentiary ruling sustaining a state's imposition of the clear and convincing evidence standard when this right is invoked as life nears its end, *id.* at 280-85, and at 292 (O'Connor, J., concurring). But *Cruzan* cannot be read as holding that the Due Process Clause protects an unqualified liberty interest of a person to suicide, much less that a dying patient has a right to involve physicians in acting against the centuries-old tradition reflected in the Hippocratic oath. To argue that the right to be free from medical intervention includes an affirmative right to assistance in dying flies in the face of the very limited language in *Cruzan*. The Ninth Circuit's view is also contrary to cases in which this Court has held that there is no right to state provision of assistance, even as to conduct the Court has found constitutionally protected. *Harris v. McRae*, 448 U.S. 297 (1980); *Maher v. Roe*, 432 U.S. 464 (1977); *Poelker v. Doe*, 432 U.S. 519 (1977); *Beal v. Doe*, 432 U.S. 438 (1977).

Both before and after *Cruzan*, several commentators have recognized the importance of drawing a clear line between killing and letting die, because this distinction offered courts an objective standard that would enable them to recognize the right to refuse certain medical treatment without also recognizing a right to suicide or euthanasia. *See, e.g.*, Lawrence H. Tribe, Governmental Control Over the Body: Decisions About Death and Dying, *American Constitutional Law* § 15-11, p. 1365 (2d ed. 1988); Mark Chopko and Michael Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 520, 564-67 (1995).

D. Misguided reliance upon *Casey*

The Ninth Circuit also relied on language in *Planned Parenthood v. Casey*, 112 S. Ct. 2791 (1992). No. 96-110, Pet. App. A-56 to A-58. In reaffirming a person's liberty interest in controlling intimate and personal decisions about abortion, Justices O'Connor, Souter, and Kennedy wrote in *Casey*: "These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of the liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State." *Casey*, 112 S. Ct. at 2807. The Ninth Circuit cited this statement in *Casey*, Pet. App. A-56, and drew from it the conclusion that when patients are in great pain, they have a similar liberty interest not only to hasten their death rather than continue to live in pain, but also to implicate the medical profession in this choice. Pet. App. A-57 to A-58.

This analysis is seriously flawed. This court in *Casey* spoke only about a constitutionally grounded right to liberty in the context of defining the future and ongoing living of a life. This language should not be removed from the context of living to the context of death, where its meaning lies beyond all of us. The Court intimated no views whatever about a constitutionally grounded right to die. *See* Chopko and Moses, *Assisted Suicide, supra*, 70 Notre Dame L. Rev. 520, 558-64. The language from *Casey* cited above should not be removed from the context in which it was uttered. As Judge Noonan noted in the original panel decision in the Ninth Circuit, "It is commonly accounted an error to lift sentences or even paragraphs out of one context and insert the abstracted thought into a wholly different context. To take three sentences out of an opinion over thirty pages in length dealing with the highly charged subject of abortion and to

find these sentences 'almost prescriptive' in ruling on a statute proscribing the promotion of suicide is to make an enormous leap, to do violence to the context, and to ignore the differences between the regulation of reproduction and the prevention of the promotion of killing a patient at his or her request." No. 96-110. Pet. App. D-11.

E. The Impossibility of Establishing Reliable Criteria for Limiting Physician-Assisted Suicide

The inappropriateness of expanding the language in *Casey* cited above to the question presented in these cases is confirmed by focusing on the illusory nature of the lower court's attempt to confine the new right to physician-assisted suicide that they have discovered in the Fourteenth Amendment.[4] The lower courts defend the creation of a constitutional right to physician-assisted suicide because they are confident that this right would operate under five carefully confined conditions. They believe that the right will be exercised only by (1) *competent patients*, (2) who *voluntarily decide to hasten death*, (3) who are *terminally ill*, (4) who *are suffering acute pain*, and (5) to whom *a physician would prescribe or provide a lethal dose of medication for the patients to take, or would actually administer a lethal dose to the patients in some circumstances*. We comment briefly on each of these categories to illustrate how unstable and unreliable they are, and to call into question the claim that a regime of physician-assisted suicide would in fact promote personal liberty.

First, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by *competent* patients. *See, e.g.*, No. 95-1858, Pet. App. 4a, 5a, 6a, 7a, 11a, 12a, 19a, 24a, 31a, 33a; and No. 96-110, Pet.

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[4] This section of the brief relies heavily on an article by Susan R. Martyn and Henry J. Bourguignon, *Physician Assisted Suicide: The Lethal Flaws of the Ninth and Second Circuit Decisions*, which will appear in 85 Cal. L. Rev. ___ (Mar. 1997). A copy of the manuscript has been served on the parties and placed in the Library of the Court.

App. A-10, A-11, A-12, A-14, A-17, A-20, A-21, A-29, A-59, A-60, A-62. This standard, however, is by no means a bright line test. Neither law nor medicine provides a simple, clear litmus test to determine patient competence. For a discussion of the complexity of the legal tests for competence, *see* John Perry, *Incompetency, Guardianship, and Restoration*, and *Decision-Making Rights over Persons and Property*, in Samuel Brakel et al, eds., *The Mentally Disabled and the Law* (1985); Thomas Gutheil and Harold Burstztjn, *Clinicians' Guidelines for Assessing and Presenting Subtle Forms of Patient Incompetence in Legal Settings*, 143 Am. J. Psychiatry 1020 (1986); S. McCrary and A. Walman, *Procedural Paternalism in Competency Determination*, 18 Law, Med. and Health Care 108, 112 (1990). Serious illness, moreover, often requires powerful medications that can alter the patient's level of competence. So can pain and suffering, fear of an unknown future, and dependence on health-care providers. In the context of physician-assisted suicide, a patient should not be deemed competent unless he truly understands not only his medical condition, but also the health care options available to treat it, including care in alternative facilities or at home. And it would mean that alternatives to suicide be genuinely accessible to the patient. Competence in this setting is thus not easy or inexpensive to assure. Unlike other mistakes that occur around the issue of patient competence, a mistake in construing a patient's desires as a request for physician-assisted suicide is, of course, irreversibly fatal.

Second, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by patients who *voluntarily* want to end their lives. *See, e.g.*, No. 95-1858, Pet. App. 5a, 34a; No. 96-110, Pet. App. A-9, A-10, A-11, A-12, A-14, A-17, A-18, A-20, A-21, A-49, A-65, A-75. At best, this line is elusive and treacherous.[5] If it is difficult to

[5] For example, the Ninth Circuit expressly approved nonvoluntary termination of life in the cases of incompetent patients. Pet. App. A-101, note 120.

determine whether a request for physician-assisted suicide is made by a competent patient, it is far more difficult to assure that such a choice is truly voluntary, for choice is often clouded. Many persons who request suicide are "beset with ambivalence, simply wish to reduce or interrupt anxiety or are under the influence of drugs, alcohol or intense pressure." Tom L. Beauchamp and James F. Childress, *Moral Problems of Suicide Intervention* in Tom L. Beauchamp and Robert M. Veatch, *Ethical Issues in Death and Dying* 127, 128 (1996). Further, such a person may entertain rescue fantasies. A "competent" request for suicide actually may convey a deep desire for relief from the distressing realities currently confronting the person. When this occurs, granting assistance in suicide actually disregards the patient's true intent. Edwin Ringel, *Suicide Prevention and the Value of Human Life*, in Beauchamp and Veatch, *supra*, at 144. Even if one assumes, as the Ninth and Second Circuits did, that a patient's suicide request can be truly voluntary, assessing what such a request means will often be impossible without a psychiatric evaluation. Depression, the major precursor of suicidal intent, worms its way into many serious illnesses and disabilities. And depression, especially among the elderly, often remains underdiagnosed and untreated. Given the dependence of ill persons on insurance companies and other health care providers whose motive is to maximize profits, moreover, a "right" to die could well be transformed into a duty to die imposed upon a helpless person to alleviate the burdens of rising medical costs. In this all too plausible scenario, true personal autonomy is lost when the quick way out is urged upon the patient by his doctor. It is bizarre to defend physician-assisted suicide as an exaltation of personal freedom. We call it a program of advancing the economic self-interest of large health corporations; we call it professional control over death and its discussion.

Third, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by *terminally ill* patients. *See, e.g.*, No. 95-1858, Pet. App. 4a, 5a, 6a, 7a, 15a, 25a; No. 96-110, Pet. App. A-9, A-10, A-13, A-14,

A-15, A-16, A-17, A-18, A-20, A-21, A-48, A-49, A-51. The timing of death, however, with its silent footsteps, often lies beyond the scientific prognostication of modern medicine. Thus state courts have noted the difficulty of defining the category, "terminally ill," with precision. "Predicting that a condition is 'terminal' within any specific time period or opining on the 'imminence' of death has been very difficult for the medical profession. . . . Distinguishing between serious illnesses, life-threatening conditions, and terminal illnesses is frequently difficult for physicians and nearly impossible for the legal community." *Browning v. Herbert*, 543 So. 2d 258, 268 (Fla. Dist. Ct. App. 1989), *aff'd*, 568 So. 2d 4 (Fla. 1990). *See also* Joanne Lynn, *Caring at the End of Our Lives*, 335 New Eng. J. Med. 201 (1996) (noting that if the definition of "terminally ill" referred to persons with a 50 percent chance of living six months, most of the frail elderly in nursing homes would be considered terminally ill). Thus Judge Noonan noted accurately in No. 96-110, "The category created ["terminally ill"] is inherently unstable. The depressed twenty-one year old, the romantically-devastated twenty-eight year old, the alcoholic forty-year old who choose suicide are also expressing their views of the existence, meaning, the universe, and life; they are also asserting their personal liberty. If at the heart of the liberty protected by the Fourteenth Amendment is this uncurtailable ability to believe and to act on one's deepest beliefs about life, the right to suicide and the right to assistance in suicide are the prerogative of at least every sane adult. . . . If such liberty exists in this context, as *Casey* asserted in the context of reproductive rights, every man and woman in the United States must enjoy it." No. 96-110, Pet. App. D-12. For a graphic example of a physician-assisted suicide involving a person who was by no means "terminally ill," *see People v. Kevorkian*, 534 N.W. 2d 172 (Mich. App. 1995).[6] *See also* Yale

[6] According to one commentator, Kevorkian's primary goal as a pathologist has always been the use of tissue from newly dead bodies for medical experimentation. Robert A. Burt, *Choosing Death for Oneself/for Others* in Lotta Westerhill and Charles Phillips, eds., *Patient's Rights: Informed Consent, Access and Equality* 63, 80-82 (1994). Another commentator notes that medical advocates for assisted suicide like Kevorkian will be most successful with vulnerable women. Stephanie Gutmann, *Death and the Maiden*, 214 New Republic (June 24, 1996) 20-28. For example, in the case cited above, when Kevorkian assisted Janet Adkins to commit suicide, she had been diagnosed with Alzheimer's disease and feared what the disease would do to her in the future. She was 54 years old, was not in imminent danger of death, and was not suffering pain. Kevorkian did not independently confirm her diagnosis or attempt to discover whether she was depressed.

Kamisar, *"Are Laws Against Assisted Suicide Unconstitutional?"* 23 Hastings Center Report 32, 36-37 (1995).

Fourth, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only by patients who are *suffering considerable pain*. No. 95-1858, Pet. App. 5a; No. 96-110, Pet. App. A-9, A-11, A-13, A-48, A-52, A-53. This assumption, however, provides no meaningful standard either. It is also misguided because it ignores the enormous progress in recent years in providing palliative care, which eases pain without curing the patient. See Derek Doyle, *The Physical Control of Pain* in Derek Doyle, ed., *Palliative Care: The Management of Advanced Illness* (1984). Today, in settings where staff has adequate training, it is now routine to control pain fairly easily in 98% of all patients, and to manage pain in those rare cases where pain control is more difficult. *See* Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 J.A.M.A. 474 (1996); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 N. Eng. J. Med. 1124 (1996). The very concept of "pain," moreover, is itself a fluid one that does not afford precise guidance for those who would have to administer a newly created regime of physician-assisted suicide. For a graphic example of a physician-assisted suicide involving a person who was probably depressed at the news of her diagnosis, but was not otherwise clinically "suffering pain," *see People v. Kevorkian*, 534 N.W. 2d 172 (Mich. App. 1995).

Fifth, the lower courts assume that a constitutional right to physician-assisted suicide would be exercised only in an environment where a physician would prescribe or provide a lethal dose of medication for the patients to take, or where a physician would actually administer the lethal dose to the patients in some circumstances. *See, e.g.*, No. 95-1858, Pet. App. 4a, 12a; No. 96-110, Pet. App., A-9, A-111, A-112. This line, however, is as questionable and untrustworthy as the other four, given the fact that so many in this country have no physician at all to whom they can turn for health care, let alone a physician with whom they have a personal relationship of trust. As we note below, moreover, the state may preserve the integrity of the physician's practice and the traditional role of the doctor in our society, which has been that of a healer, not of a minister of death. In our society doctors are widely recognized as professionals dedicated to delivering, restoring, saving and comforting life. Some doctors are better at this than others, but all doctors – irrespective of their technical skills or particular training – are expected to support life rather than to destroy life. In a regime of physician-assisted suicide, at least some doctors will be recognized as promoters of swift death. The ineluctable result will be that patients will not have the same trust and confidence in the advice their doctors offer. Most troubling, even a suggestion of the possibility that death might be hastened, when made by a doctor to a seriously ill, dependent and suffering patient, will force the patient to justify her remaining existence. We dare not call this "compassion." Indeed, the entire approach of the Ninth Circuit is based on a total misunderstanding of the virtue of compassion, which has to do with bonding with the other and with empathetic caring for the other, not with directly intending to cause the death of the other.

The supposed protections offered by the lower courts turn out to provide an insecure, elusive and deceptive line of defense against abuse. Asserting that only competent, terminally ill patients who voluntarily choose to end their lives because of their intolerable pain will be granted the assistance

of a doctor in ending their lives, is a claim that no legal system can guarantee, a line no court can enforce. If this Court creates a constitutional regime of physician-assisted suicide, even if the patient who is helped to die was not competent to make the decision, or even if the patient's decision was not fully voluntary, or even if the patient was not terminally ill, or even if the patient did not suffer from intolerable and unrelievable pain, or even if the aid in dying was not given by a physician – there will seldom if ever be a successful prosecution. Many will die; few seriously ill persons will be protected.

None of the five elements discussed above is a reliable criterion for a stable constitutional test that would ensure that physician-assisted suicide will be cabined in a manner that would enhance personal liberty. When combined into a five-part test, they do not improve as stable predictors of the future. The line protecting against involuntary euthanasia – even state-encouraged involuntary euthanasia – simply does not hold. The activity allowed by physician-assisted suicide will inevitably fail to satisfy the appetite of those who support it; they will mount unrelenting pressure to expand the limits of the permissible and to go beyond it. The journey down the slippery slope is far too risky to undertake at all, much less on the flimsy assurances against future abuse offered by the lower courts. The line we insist should be maintained between killing a person and allowing a person to die might not always be a perfectly clear line, but over a long period of time it has been vastly more effective at preventing abuse than the untenable line proposed by the lower courts.

F. Legitimate Governmental Interests in Prohibiting Physician-Assisted Suicide

As we have suggested above, to defend a regime of physician-assisted suicide under the rubric of liberty begs a very important question about whose liberty would in fact be promoted by this change. When a state preserves the distinction between killing a person and allowing a person to die, it

promotes the interest in personal liberty; a regime of physician-assisted suicide would not.

Judge Noonan identified five legitimate governmental interests that undergird the prohibition of physician-assisted suicide: (1) the interest in not having physicians in the role of killers of their patients; (2) the interest in preventing abuse similar to what has occurred in the Netherlands where the practice of allowing assisted suicide now includes direct measures taken to end a person's life without a contemporaneous request to do so; (3) the interest in not subjecting the elderly and even the not-elderly but infirm to psychological pressure to consent to their own deaths; (4) the interest in protecting the poor and minorities from exploitation; and (5) the interest in protecting persons who are disabled from societal indifference and antipathy. No. 96-110, Pet. App. D-14 to D-17. We discuss the first two interests in this section of the brief because they are directly related to the theme of personal liberty, and the last three interests in Part II below because they are related to the theme of equality. In articulating these governmental interests, Judge Noonan relied on the most comprehensive study of physician-assisted suicide by a governmental body, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* (1994).[7] We now discuss

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[7] The study was conducted by the New York State Task Force, a commission appointed by Governor Cuomo in 1985, which filed its report in May, 1994. The Task Force was composed of twenty-four members representing a broad spectrum of ethical and religious views and ethical, health, legal, and medical competencies. Its membership disagreed on the morality of suicide. Unanimously the members agreed against recommending a change in New York law to permit assisted suicide. Thus it strikes us as bizarre that a judge in the Second Circuit could have suggested that the issue be remanded to the political process in New York, which had just completed an exhaustive treatment of the issue and had expressly rejected the conclusion urged by the lower court. No. 95-1858, Pet. App. 43a-44a (Calabresi, J., concurring). The en banc opinion in the Ninth Circuit cited this Task Force Report in a footnote, No. 96-110, Pet. App. A-74 note 84, but its opinion does not indicate that the en banc panel actually read the document they asked their readers to "see."

two governmental interests that bear more directly on the theme of personal liberty.

(1) Protecting the role of physicians as healers, not killers.

First, a state has a legitimate interest in not having physicians in the role of killers of their patients. One way of thinking of this interest is that the state may preserve the integrity of the physician's practice, which has for centuries explicitly prohibited doing any harm to patients.[8] More recently and more explicitly, § 2.211 of the American Medical Association's *Code of Medical Ethics* (1994) declares: "Physician-assisted suicide is fundamentally incompatible with the physician's role as healer."

Another way of thinking of the legitimacy of this governmental interest is that it concerns public health or the well-being of the entire community. Thus, as Judge Noonan suggested, "Not only would the self-understanding of physicians be affected by removal of the state's support for their professional stance; the physician's constant search for ways to combat disease would be affected, if killing were as acceptable an option for the physician as curing. The physician's commitment to curing is the medical profession's commitment to medical progress." No. 96-110, Pet. App. D-15. When the well-being of all persons is diminished by a shift in constitutional standards, that shift cannot be defended as an enhancement of personal liberty.

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[8] For an extensive treatment of the significance of the Hippocratic Oath, *see* Nigel Cameron, *The New Medicine: Life and Death after Hippocrates* (1991); Owsei Temkin, *Hippocrates in a World of Pagans and Christians* (1991); Ludwig Edelstein, *The Hippocratic Oath: Text, Translation, and Interpretation* (1943); and *see* Brief Amicus Curiae of Christian Medical & Dental Society in No. 95-1858 and No. 96-110.

(2) Preventing the abuse of widespread involuntary euthanasia

Second, a state has a legitimate interest in preventing involuntary active euthanasia. This abuse is not hypothetical. It has occurred in two modern democracies in our own century, the Netherlands and Germany. When these two experiences are explored carefully, several closely related propositions emerge that have a dreadful resemblance to the brave new world we fear will emerge in a regime of physician-assisted suicide. First, high-sounding generalizations about the human good can mask terrible evil. Second, massive self-deception or willful blindness sets in and prevents close empirical inspection of the established program. Third, when the purposes and effects of the norms in society are themselves evil, otherwise good people – including physicians – can become complicit in massive evil simply by taking the easy path of conforming to the "normal." Fourth, the law has an educative function for good or for ill, and a medical program that has the force of law has a powerful ability to shape culture and to confer legitimacy upon atrocity.

Since 1984, legal guidelines in the Netherlands have tacitly allowed assisted suicide or euthanasia in response to a repeated, voluntary request from a suffering, competent, terminally ill patient, the same line drawn by the courts below. In 1991 the government established the Rimmelink Committee to determine the actual number of deaths by euthanasia and to gain insight into this practice. The Rimmelink Committee discovered that by 1990, approximately 2,700 cases of assisted suicide occur annually, amounting to two percent of all deaths.[9] Within less than a decade of this shift in

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[9] In this country, two percent of deaths would amount to more than 43,000 cases of physician-assisted suicides a year. If this Court intends to set up a regime of physician-assisted suicide confident that abuse can be prevented "while this Court sits," *Panhandle Oil Co. v. Mississippi ex rel. Knox*, 277 U.S. 218, 223 (1928) (Holmes, J., dissenting), its docket will be very full of these cases for years to come.

standards, the Rimmelink Committee concluded that none of the initial lines drawn by Dutch Law had held. In the cases reported to the Committee, Dutch physicians admitted that in 1,000 additional cases they had intentionally taken the patient's life involuntarily, without an explicit request from either patient or family. And there is a large number of unreported cases in this category of "life terminating acts without the explicit request of the patient." *See* New York State Task Force, *When Death Is Sought*, 133-134; Johannes J. M. van Delden, Loes Pijnenborg and Paul J. van der Maas, *The Remmelink Study: Two Years Later*, 23 Hastings Center Report 24 (Nov.-Dec.1993); Subcommittee on the Constitution, House Jud. Comm., *Physician-Assisted Suicide and Euthanasia in the Netherlands*, 104th Cong., 2d Sess. (1996). Whatever else may be said about the sudden and widespread practice of active involuntary euthanasia in the Netherlands, this dramatic shift away from patient involvement in such a momentous decision cannot plausibly be justified as an enhancement of personal liberty.

Recent studies also enable sharp focus on the Nazi program of physician-assisted eugenics and euthanasia that was central to its plan of creating an ethnically pure super-race. *See* Nigel Cameron, *The New Medicine: Life and Death after Hippocrates* 68-91 (1991); Ingo Muller, *Hitler's Justice: The Courts of the Third Reich* 120-26 (1991); Robert Proctor, *Racial Hygiene: Medicine under the Nazis* (1988); Benno Muller-Hill, *Murderous Science* (1988); Robert J. Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* 46-79 (1986). Because of the massive evils perpetrated by the Nazis, *see, e.g.*, Lucy Davidowitz, *The War Against the Jews, 1993-1945* (1975), it is easier to see clearly the evil of the Third Reich than to recognize an analogous situation in the Netherlands or in our own society. As churches with deep historical roots in Germany, we have reflected soberly on the full horror of the Third Reich and on the tragic complacency of the church in the face of that horror. We have searched

fearlessly in this history for sobering lessons that apply to all cultures, including our own.

We acknowledge important differences between Nazi Germany and the current situation of involuntary euthanasia in the Netherlands or the regime we fear would occur in our own country if physician-assisted suicide is imbedded as a constitutional right. And we do not suggest any ideological connection between the Nazis and the respondents or their advocates. Nevertheless, we urge that some lessons might be gleaned from the past as we stand at the precipice of the creation of a new legal order in this country. At least in some respects, the role of some doctors in our future would be distressingly similar to the role some doctors were asked to play in the Third Reich, when large numbers of people in certain groups were judged "unworthy of life." See Lifton, *The Nazi Doctors, supra,* 21-144. That should be enough to give us pause before marching forward in this direction. At the very least, this Court should not lightly toss aside the decision of a state to stand firm by its commitment against physician-assisted suicide in the wake of the experience in the Netherlands.

II. Preserving the distinction between killing a person and allowing a person to die promotes the equal dignity of all persons; a regime of physician-assisted suicide would not.

As we noted above, the Second Circuit repudiated the Ninth Circuit's discovery of a liberty interest in physician-assisted suicide through the methodology of substantive due process. No. 95-1858, Pet. App. 16a-20a. But it held that "[t]he New York statutes criminalizing assisted suicide violate the Equal Protection Clause because, to the extent that they prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally-ill person in the final stages of his terminal illness, they are not rationally related to any legitimate state interest." No. 95-1858, Pet. App. 35a. We note again the language relied

upon by the Second Circuit to prevent abuse from physician-assisted suicide, and repeat that – especially in the wake of the recent experience in the Netherlands – these standards afford no protection against sliding down a very slippery slope towards widespread involuntary euthanasia. The narcissistic impulse, moreover, is so deeply entrenched in human life that we have no solid ground for trusting the court's naive faith in the inherent generosity of human compassion.

Although the equal protection methodology employed by the Second Circuit differs at least formally from the substantive due process methodology employed by the Ninth Circuit, the equal protection approach turns out to be just another way of imposing raw judicial power over the political process. Both courts attack the legitimacy of any governmental interest in prohibiting physician-assisted suicide. Since the Second Circuit conceded that there is no fundamental right to suicide, whether assisted or not, it should have deferred to the legislative judgment protecting human life. *See, e.g., Califano v. Aznavorian*, 439 U.S. 170 (1978); *New Orleans v. Dukes*, 427 U.S. 297 (1976); *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955). Instead, it nullified the New York statute for essentially the same reasons as those offered by the Ninth Circuit. Only the constitutional shell is different. Hence the reasons we offered in Part I obtain with equal force here.

We comment now on the three other legitimate governmental interests identified by Judge Noonan because they bear directly on the theme of equality.

A. Protecting the elderly infirm from the grave risk of involuntary euthanasia.

A state has a legitimate interest in not subjecting the elderly infirm to psychological pressure to consent to their own deaths. The value of equality in our society may be described as a widening circle of inclusion. For example, at the dawn of the republic, African slaves and women were emphatically not regarded as equal in the eyes of the law. But radical constitutional changes imbedded in the Fifteenth and

Nineteenth Amendments have at least signalled that African-Americans and women are now constitutionally entitled to participate in our democracy by means of the franchise. More recently, momentous legislation has banned invidious discrimination on the basis of race in access to public accommodations, 42 U.S.C. § 2000a (Title II of Civil Rights Act of 1964), on the basis of race and gender in employment, 42 U.S.C. § 2000e (Title VII of Civil Rights Act of 1964), and on the basis of race in housing, 42 U.S.C. §§ 3601 et seq. (Title VIII of Civil Rights Act of 1968). More recently still, older persons have also been protected under the law. *See, e.g.*, 29 U.S.C. §§ 621 et seq. (prohibiting discrimination in employment on the basis of age within specified period of years).

We do not propose that all government policies that would have the effect of placing more significant burdens on older persons must be subject to the most exacting scrutiny previously reserved for racial classifications, or even to the intermediate scrutiny employed in cases involving gender-based classifications. But where, as here, a majority of the states has acted affirmatively to insure that older persons are surrounded with the protection of the laws, we do suggest that it is legitimate for this Court to find that the states have a rational basis for doing so. There is, in short, a plausible connection between a state's prohibition of physician-assisted suicide and its concern for older persons. For one thing, older persons are more vulnerable to the suggestion that, having lived a full life, they have now become a burden to society and even to their family. In these circumstances, it is not unreasonable to maintain that doctors should be the champions and best friends of older persons, not the state-approved harbingers and agents of their death. As Judge Noonan noted, "For all medical treatments, physicians decide which patients are the candidates. If assisted suicide was acceptable professional practice, physicians would make a judgment as to who was a good candidate for it. . . . 'Once the physician suggests suicide or euthanasia, some patients will feel that they have few, if any alternatives, but to accept the recommendation.' "

No. 96-110, Pet. App. D-15, D-16 (citing New York State Task Force, *When Death Is Sought*).

B. Protecting the poor and minorities from the grave risk of involuntary euthanasia.

A state has a legitimate interest in protecting all persons, especially those without access to health care, from exploitation. In our country over 40 million have no health care insurance at all, and managed health care has increasingly allocated health care services to maximize the economic interests of investors in health care organizations. Under these circumstances, we are deeply troubled that in a regime of physician-assisted suicide health care managers could easily rationalize a decision to induce the death of an unwanted and vulnerable person, whose value in such a system would be measured exclusively in economic terms.

As we noted above, the theme of equality is a widening circle of inclusion. At the beginning of the republic, only property-owners could vote. Again, momentous changes in our century now ensure that the poor may participate in the democracy by means of the franchise. U.S. Const., Amend. XXIV. 42 U.S.C. § 1973 (Voting Rights Act of 1965, as amended); and *Kramer v. Union Free School Dist. No. 15*, 395 U.S. 621 (1969) (eliminating qualification of property ownership for participating in school board elections).

We realize that this Court does not recognize poverty as a suspect classification for purposes of equal protection analysis. *See, e.g., San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1 (1972). These cases are not the vehicle for advocating any change in this approach now. But where, as here, a majority of the states has acted affirmatively to insure that all persons – irrespective of their financial ability to pay for adequate health care[10] – are surrounded with the protection of

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[10] The burden of inadequate health care continues to fall most heavily on the poor and minorities. *See, e.g.*, Marian Gornich et al., *Effects of Race*

the laws, it is legitimate for this Court to find that the states have a rational basis for doing so. As Judge Noonan noted, "The poor and minorities would be especially open to manipulation in a regime of assisted suicide for two reasons: Pain is a significant factor in creating a desire for assisted suicide, and the poor and minorities are notoriously less provided for in the alleviation of pain. The desire to reduce the cost of public assistance by quickly terminating a prolonged illness cannot be ignored: 'the cost of treatment is viewed as relevant to decisions at the bedside.' Convergently, the reduction of untreated (although treatable) pain and economic logic would make the poorest the primest candidates for physician-assisted and physician-recommended suicide." No. 96-110, Pet. App. D-16 (citing New York State Task Force, *When Death Is Sought*).

C. Protecting older persons from the grave risk of involuntary euthanasia.

A state has a legitimate interest in protecting all persons who are disabled from societal indifference and antipathy. The widening circle of inclusion has recently expanded to embrace persons with disabilities within its perimeters. Until fairly recently such persons could not participate fully in economic life. The law rendered them invisible as a group. Again, momentous changes in the law now ensure that the disabled may gain access to buildings and thus to education and employment. *See, e.g.*, Vocational Rehabilitation Act of 1973, 29 U.S.C. § 794; Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6001; Americans with Disabilities Act, 42 U.S.C. §§ 12601 et seq.

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and Income on Mortality and Use of Services Among Medicare Beneficiaries, 335 N. Eng. J. Med. 791 (1996). Thus the state would have an additional reason to ensure that these groups are not singled out for swift elimination because of class or racial prejudices masked under the label of physician-assisted suicide.

We recognize that this Court does not recognize disability as a suspect classification for purposes of equal protection analysis. *See, e.g., City of Cleburne v. Cleburne Living Center*, 473 U.S. 432 (1985). Again, we do not urge a change in this approach now. We merely note that where, as here, a majority of the states has acted affirmatively to insure that persons with disabilities are surrounded with the protection of the laws, it is legitimate for this Court to find that the states have a rational basis for doing so.

As Judge Noonan noted, "The vulnerability of residents of nursing homes and long-term care facilities to physician-assisted suicide is foreshadowed in the discriminatory way that a seriously-disabled person's expression of a desire to die is interpreted. When the nondisabled say they want to die, they are labelled as suicidal; if they are disabled, it is treated as 'natural' or 'reasonable.' *See* Carol J. Gill, *Suicide Intervention for Persons with Disabilities: A Lesson in Inequality*, 8 Issues in Law & Med. 37, 38-39 (1993). In the climate of our achievement-oriented society, 'simply offering the option of 'self-deliverance' shifts a burden of proof, so that helpless patients must ask themselves why they are not availing themselves of it.' Richard Doerflinger, *Assisted Suicide: Pro-choice or Anti-Life?*, 19 Hastings Center Report 16, 17 (1989). An insidious bias against the handicapped – again coupled with a cost-saving mentality – makes them especially in need of Washington's statutory protection." No. 96-110, Pet. App. D-16.

Individually and convergently, the five legitimate governmental objectives discussed here outweigh any alleged constitutional liberty of suicide or of assistance in suicide by the medical profession. Both methodologies employed by the lower courts fail on their own terms.

CONCLUSION

Both lower courts have proposed a new constitutional order that would in a single stroke undermine the healing function of doctors by allowing them to become ministers of

death. Yet each court has cast doubt on the rationale of the other. The Second Circuit expressly rejected the substantive due process claim to assisted suicide adopted by the Ninth Circuit. The original panel in the Ninth Circuit rejected the equal protection claim that formed the basis for the analysis espoused by the Second Circuit; the en banc panel did not reach this claim. Thus the judges who would impose this result on our nation have not produced a coherent rationale for the startling departure in criminal law and constitutional interpretation that they propose. Uncertainty abounds on both predicates for the decisions advanced below. This court should not create a new constitutional regime of physician-assisted suicide, which would neither advance human freedom nor promote the equal dignity of all persons. The wiser course of action for this Court to pursue would be to reaffirm the role of the several states in surrounding human life with protection. The lower courts should be reversed.

Respectfully submitted,

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APPENDIX A

The Evangelical Lutheran Church in America, 1992 Message on End-of-Life Decisions

With this message, the Church Council of the Evangelical Lutheran Church in America, upon the recommendation of the Division for Church in Society, addresses some timely aspects of end-of-life situations and encourages further deliberation on the topic throughout this church. This message does not deal with the full scope of these complex matters. It draws upon a relevant social statement, "Death and Dying," of a predecessor church body as basis for the guidance it offers.[1]

The Occasion

An elderly woman contemplates in terror the possibility that she might be kept alive for months by means of life-support systems. A son visits a nursing home weekly to see his 95 year-old mother, who is stricken with Parkinson's disease and who wants to die. Family and friends share the slow, anguishing death of a young man with AIDS. Parents agonize with their pastor over what to do about their daughter who survives in a persistent vegetative state after a car accident.

Increasingly, people know from their own experience similar painful dilemmas. While the achievements of modern medicine have been used to prolong and enhance life for many, they have also helped create an often dreaded context for dying. Costly technology may keep persons alive, but frequently these persons are cut off from meaningful relationships with others and exist with little or no hope for recovery. Many fearfully imagine a situation at the end of their lives where they or their trusted ones will have no say in decisions about their treatment.

In this context, new emphasis is being placed on the rights of patients. Recent federal legislation, for example, requires all health care facilities receiving Medicare or Medicaid monies

to inform patients of their right to make medical treatment decisions. This includes the right to specify "advance directives,"[2] which state what patients wish to be done in case they are no longer able to communicate adequately.

We consider the legislation consistent with the principle that "respect for that person [who is capable of participating] mandates that he or she be recognized as the prime decision-maker" in treatment.[3] The patient is a person in relationship, not an isolated individual. Her or his decisions should take others into account and be made in supportive consultation with family members, close friends, pastor, and health care professionals. Christians face end-of-life decisions in all their ambiguity, knowing we are responsible ultimately to God, whose grace comforts, forgives, and frees us in our dilemmas.

Which decisions about dying are morally acceptable to concerned Christians, and which ones go beyond morally acceptable limits? Which medical practices and public policies allow for more humane treatment for those who are dying, and which ones open the door to abuse and the violation of human dignity? Proposals in various states to legalize physician-assisted death[4] point to renewed interest in these old questions. ELCA members, congregations, and institutions need to address these questions through prayer and careful reflection.

A Christian Perspective

Our faith as Christians informs and guides us in approaching personal and public decisions about death and dying today. Among the convictions that orient us are:

- life is a gift from God, to be received with thanksgiving;
- the integrity of the life processes which God has created should be respected; both birth and death are part of these life processes;

- both living and dying should occur within a caring community;
- a Christian perspective mandates respect for each person; such respect includes giving due recognition to each person's carefully considered preferences regarding treatment decisions;
- truthfulness and faithfulness in our relations with others are essential to the texture of human life; and,
- hope and meaning in life are possible even in times of suffering and adversity a truth powerfully proclaimed in the resurrection faith of the church.[5]

"Whether we live or whether we die, we are the Lord's" (Romans 14:8). For those who live with this confidence, neither life nor death are absolute. We treasure God's gift of life; we also prepare ourselves for a time when we may let go of our lives, entrusting our future to the crucified and risen Christ who is "Lord of both the dead and the living" (Romans 14:9).

While these convictions do not give clear-cut answers to all end-of-life decisions, they do offer a basic approach to them.

Allowing Death and Taking Life

Withholding or Withdrawing Artificially-administered Nutrition and Hydration

Patients who once would have died because of their inability to take food and water by mouth can today be kept alive through artificially-administered nutrition and hydration. These measures are often temporary and allow many to recover health. At other times, however, they alone maintain life, and they may do so indefinitely. In those cases, is it ever morally permissible to withhold or withdraw such measures?

Food and water are part of basic human care. Artificially-administered nutrition and hydration move beyond basic care to become medical treatment. Health care professionals are not required to use all available medical treatment in all circumstances. Medical treatment may be limited in some instances, and death allowed to occur. Patients have a right to refuse unduly burdensome treatments which are disproportionate to the expected benefits.

When medical judgment determines that artificially-administered nutrition and hydration will not contribute to an improvement in the patient's underlying condition or prevent death from that condition, patients or their legal spokespersons may consider them unduly burdensome treatment. In these circumstances it may be morally responsible to withhold or withdraw them and allow death to occur. This decision does not mean that family and friends are abandoning their loved one.

When artificially-administered nutrition and hydration are withheld or withdrawn, family, friends, health care professionals, and pastor should continue to care for the person. They are to provide relief from suffering, physical comfort, and assurance of God's enduring love.

Refusal of Beneficial Treatment

Patients and health care professionals share a common concern that medical treatment be beneficial. In most situations, they have a common understanding of that benefit. When agreement exists, patients generally are willing to receive treatment. There are situations, however, when patients and health care professionals disagree on what will benefit the patient, or on whether the expected benefit is worth the risks and burdens involved. What is morally responsible in these situations?

Because competent patients are the prime decision-makers, they may refuse treatment recommended by health care professionals when they do not believe the benefits outweigh the risks and burdens. This is also the case for patients who are incompetent, but who have identified their wishes through advance directives, living wills, and/or conversation with family or designated surrogates.

Health care professionals are obligated to inform patients of medical treatment options and what in their best judgment are the potential benefits and burdens of such options. They are also obligated to obtain the consent of patients to provide treatment. Where this consent is not given, they should accept the desired limits of treatment, even when they do not agree with the decision.

A patient's refusal of beneficial treatment does not free health care professionals from the obligation to give basic human care and comfort throughout the dying process which may follow. Family, friends, and pastor need to accompany the person and share the promise of God's faithfulness in life and death.

Physician-Assisted Death

An emphasis on patients' rights, a health care system often unable to respond adequately to catastrophic illness, and the emergence of disease processes (such as AIDS and Alzheimer's disease) that threaten dramatic loss of human capacities are a few of the realities that have converged to create an environment where some patients ask that their life be ended. Is it ever morally permissible for a physician deliberately to act or authorize an action to terminate the life of a patient?

The integrity of the physician-patient relationship is rooted in trust that physicians will act to preserve the life and health of the patient. Physicians and other health care professionals

also have responsibility to relieve suffering. This responsibility includes the aggressive management of pain, even when it may result in an earlier death.

However, the deliberate action of a physician to take the life of a patient, even when this is the patient's wish, is a different matter. As a church we affirm that deliberately destroying life created in the image of God is contrary to our Christian conscience.[6] While this affirmation is clear, we also recognize that responsible health care professionals struggle to choose the lesser evil in ambiguous borderline situations – for example, when pain becomes so unmanageable that life is indistinguishable from torture.

We oppose the legalization of physician-assisted death, which would allow the private killing of one person by another. Public control and regulation of such actions would be extremely difficult, if not impossible. The potential for abuse, especially of people who are most vulnerable, would be substantially increased.

Caring treatment that allows death to occur within the bounds of what is morally acceptable may help reduce the appeal of physician-assisted death. Hospice care offers promise of more humane treatment at the end of life. A more equitable health care system that more effectively responds to catastrophic illness and provides the needed follow-up care should also be a priority for those concerned about end-of-life decisions.

Ministry in Preparation for the End of Life

Advance directives are welcome means to foster responsible decisions at the end of life. Yet people are often overwhelmed and frightened when thinking about medical treatment and legal possibilities, and therefore do not take steps to prepare for the end of their lives. People recognize their rights as patients but at the same time feel unprepared to take on the responsibility.

Communities of faith should, can, and often do provide holistic ministry to prepare people for end-of-life decisions. Pastors can help people to deal with their fears and hopes. Congregations can offer opportunities for conversation and deliberation about the end of life. They can invite hospital chaplains, hospice care-givers, social workers, attorneys, or others knowledgeable about advance directives to help them consider the topic's many dimensions.

Church related hospitals, nursing homes, and other social ministry organizations are also encouraged to provide for continuing conversation and deliberation about their ministry at the end of life. The staff of these organizations need to understand the ethical principles that are to guide the care they provide. Ethics committees can play an important role in dealing with unresolved conflicts about treatment decisions.

We rejoice in the faithful and compassionate congregations, pastors, health care professionals, and church institutions who minister with persons who are dying and their families and friends. We give thanks for family and friends who minister to their loved ones. In the midst of often agonizing end-of-life decisions, we are reminded of the God-given mystery of both life and death. May the Holy Spirit grant to us all loving wisdom and confident hope in the Gospel's promise of eternal life.

Endnotes

[1] The social statement, "Death and Dying," was adopted in 1982 by the Lutheran Church in America. In 1977 The American Lutheran Church developed an analysis paper, "Death and Dying," which was not an actual social statement, but also provides background for this message. Both are available from the ELCA Distribution Service.

[2] "Advance directives" commonly include designation of a durable power of attorney, living wills, and an advance directive form. The exact meaning, however, may vary from state to state.

[3] LCA, "Death and Dying," p. 3.

[4] Physician-assisted death or "aid in dying" refers to situations in which a physician (or other health professional at the physician's request), in response to a patient's request, either administers a medication or performs a treatment, or enables the patient to do so, with the intent of bringing about that patient's death.

[5] The above convictions are quoted from LCA, "Death and Dying," pp. 2-3.

[6] LCA, "Death and Dying," p. 6.

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IN THE SUPREME COURT OF THE UNITED STATES
October Term, 1996

Dennis C. Vacco, et al.,
Petitioners

v.

Timothy E. Quill, M.D., et al.,
Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

State of Washington,
Petitioner

v.

Harold Glucksberg, et al.,
Respondents

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF THE PROJECT ON DEATH IN AMERICA, OPEN SOCIETY INSTITUTE, AS AMICUS CURIAE, FOR REVERSAL OF THE JUDGMENTS BELOW

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41pp

TABLE OF CONTENTS

Page

TABLE OF CITATIONS iv

QUESTION DISCUSSED BY AMICUS x

INTEREST OF AMICUS CURIAE 1

SUMMARY OF ARGUMENT 2

ARGUMENT 4

I. COURTS SHOULD NOT PRE-EMPT PUBLIC DEBATE AND LEGISLATIVE ACTION BY PREMATURE CONSTITUTIONAL RESOLUTION OF ISSUES WITH SUCH COMPLEX DIMENSIONS AS PHYSICIAN-ASSISTED SUICIDE 4

A. Justice Brandeis' Approach: For "Novel Social Experiments," Courts Should Withhold Constitutional Resolution While Individual States, Serving As "Laboratories," Develop Adequate Practical and Research Experience. 4

B. Regarding Physician-Patient Relations, the Modern Court Has Applied Justice Brandeis' Approach to Avoid Premature Constitutional Resolution of Novel, Factually Complex Issues. 6

C. The Modern Court Has Applied Justice Brandeis' Approach to Promote State Experimentation and Avoid Premature Constitutional Resolution in Many Other Contexts. 8

1. Interpreting the Fourteenth Amendment due process right to a fair trial 8

2. Interpreting the Eighth Amendment right against cruel and unusual punishments 9

3. Interpreting Fourteenth Amendment "privacy" or "liberty" interests. 11

II. CONSTITUTIONAL RESOLUTION IS PREMATURE BECAUSE SUBSTANTIAL UNCERTAINTIES EXIST REGARDING THE POSSIBILITY OF DESIGNING EFFECTIVE SAFEGUARDS FOR THE PRACTICE OF PHYSICIAN-ASSISTED SUICIDE 13

A. Voluntariness 15

1. A dying person suffering from intense pain cannot voluntarily choose suicide unless available, effective pain treatment is offered. 15

2. Undue financial pressures can undermine the voluntariness of a dying person's choice for suicide 20

B. Mental Competence 23

1. Judgment-impairing confusion is common among dying persons but is surprisingly difficult to identify as such. 23

2. Judgment-impairing depression is common among dying persons and, not surprisingly, is difficult to identify as such. 25

C. Prognosis of Terminal Illness 27

CONCLUSION 30

TABLE OF CITATIONS

CASES **PAGE(S)**

Chandler v. Florida,
449 U.S. 560 (1981) 8, 9

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QUESTION DISCUSSED BY AMICUS

Whether the invalidation by the courts below of state laws prohibiting physician-assisted suicide should be overruled on the ground that the issue is not yet ripe for constitutional adjudication.[1]

[1] Each party has given its consent, in writing, to the filing of this brief amicus curiae. Letters indicating such consent have been filed with the Clerk of the Court.

INTEREST OF AMICUS CURIAE

The Project on Death in America was established in 1994 by the Open Society Institute, a private non-profit operating foundation. Its mission is to understand and transform the culture and experience of dying in the United States through initiatives in research, scholarship, the humanities and the arts, and to foster innovations in the provision of care, public education, professional education, and public policy. This mission arose from a recognition, first, that the experience of dying has changed over the past several decades, with many more people enduring prolonged dying as a consequence of chronic and progressive disease and, second, that needless suffering -- physical, emotional, existential and spiritual -- too often accompanies these deaths, for both dying persons and survivors.

The Project takes no position on the question whether legal institutions should ultimately recognize a right to physician-assisted suicide, whether by legislative action or by judicial constitutional interpretation. Among individuals who are supported by, affiliated with, or responsible for the direction of the Project, there is no uniform view about whether physician-assisted suicide should be endorsed by legislative action or constitutional adjudication.

Among the enterprises supported by the Project, many are dedicated to implementing palliative care programs in hospital and community settings to alleviate the needless suffering that currently afflicts dying people and their families. Other supported programs are engaged in designing ways to enhance the autonomous choice of dying people in such matters as what treatments are provided to them, whether they die in institutional or home settings, and whether adequate financial and other community resources are available to support the choices preferred by dying people and their families. By these means, as well as by supporting evaluative research and

programs for public and professional education, the Project is addressing many of the justifiable fears that are the current predicates for the support of physician-assisted suicide, and is working to establish an adequate practical basis for evaluating effective safeguards for any future implementation of the practice of physician-assisted suicide.

Our goal is to promote a fully informed and equitable societal resolution of the question whether physician-assisted suicide should be legitimated, if at all, by legislation or as a constitutional right.

SUMMARY OF ARGUMENT

Legally recognized physician-assisted suicide is not currently in practice in any jurisdiction in the United States. It has not yet been implemented even in the one state (Oregon) where physician-assisted suicide was legalized by a popular referendum just two years ago. If this Court were to affirm the judgments below declaring a constitutional right to physician-assisted suicide, an abrupt, radical and utterly unprepared transformation of medical practice would be imposed on the entire country.

In *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), which considered a constitutional claim to refuse life-prolonging medical treatment for a mentally incompetent person, this Court proceeded with considerable caution and refused to enunciate a uniform constitutional rule, deferring instead to the "divers[e] . . . number of sources" available to states in considering such a "perplexing question with unusually strong moral and ethical overtones." *Id.* at 277. This Court thus followed Justice Brandeis' classic injunction to avoid premature constitutional decisions that close off state "experimentation" regarding "changing social . . . needs." *New State Ice Co. v. Liebmann*, 285 U.S. 262, 310 (1932) (dissenting opinion).

Following this judicious course does not necessarily foreclose some future constitutional determination regarding an individual right to physician-assisted suicide by this Court. In many other contexts -- such as constitutional interpretations of due process rights in criminal trials, and rights against cruel and unusual punishment -- this Court has purposefully and explicitly stayed its hand so that states might explore different solutions to novel, complex social problems. In these contexts, the Court has made clear that extensive prior deliberation and experimentation in Brandeis' "laboratory" of the states is a necessary prerequisite for an adequately informed, ultimate judicial decision to enunciate a uniform, binding constitutional resolution.

This necessary prerequisite of extensive state deliberation and experimentation has hardly even begun regarding legally recognized physician-assisted suicide. In particular, there are serious unanswered questions about the capacity of physicians or state officials to ensure that a gravely ill individual's choice for physician assistance in suicide is adequately voluntary, or that the individual is mentally competent or is appropriately diagnosed as terminally ill. In the instant cases, however, the Courts of Appeals held that any constitutional right to physician-assisted suicide must be limited to voluntary, mentally competent, terminally ill individuals. The courts below ignored the multiple uncertainties currently involved in applying these criteria in individual cases. Because it is not yet certain that adequate criteria can be developed or applied, it is premature for any court to determine whether there is a federal constitutional right to physician-assisted suicide. The question is not ripe for constitutional adjudication and will not become ripe for an indeterminate time while various states, free from judicially-imposed constitutional compulsion, consider whether or on what terms physician-assisted suicide should be authorized. The judgments below should accordingly be reversed.

ARGUMENT

I. COURTS SHOULD NOT PRE-EMPT PUBLIC DEBATE AND LEGISLATIVE ACTION BY PREMATURE CONSTITUTIONAL RESOLUTION OF ISSUES WITH SUCH COMPLEX DIMENSIONS AS PHYSICIAN-ASSISTED SUICIDE.

A. Justice Brandeis' Approach: For "Novel Social Experiments," Courts Should Withhold Constitutional Resolution While Individual States, Serving As "Laboratories," Develop Adequate Practical and Research Experience.

The instant case is strikingly similar to *New State Ice Co. v. Liebmann*, 285 U.S. 262 (1932). In the heyday of its invocations of substantive due process to overturn state social and economic regulations, the Court held that a state law requiring a license to manufacture, sell or distribute ice was unconstitutional on the ground that this activity was "essentially private in nature" and that "under [the fourteenth] amendment, nothing is more clearly settled than that it is beyond the power of a state, 'under the guise of protecting the public, arbitrarily [to] interfere with private business . . . '." *Id.* at 277-78. Justice Brandeis dissented from this sweeping application of the "privacy" norm, in an opinion which the modern Court has acknowledged as "classic." *Whalen v. Roe*, 429 U.S. 589, 597 n. 20 (1977).

Justice Brandeis' reasoning applies with equal force to the invocations of constitutional norms of "privacy" or "arbitrariness" to overturn state laws against physician-assisted suicide, as in the Ninth and Second Circuit rulings in the instant case. Justice Brandeis' dissent makes this application clear:

> To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the nation. It is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country. This Court has the power to prevent an experiment. We may strike down the statute which embodies it on the ground that, in our opinion, the measure is arbitrary, capricious, or unreasonable. . . . But, in the exercise of this high power, we must be ever on our guard, lest we erect our prejudices into legal principles. If we would guide by the light of reason, we must let our minds be bold.

285 U.S. at 311.

In *New State Ice Co.* the Court prevented experimentation on a complex question of social and economic policy by striking down the novel state law. But that is not the only way that constitutional adjudication can override what Justice Brandeis referred to as the "value of the process of trial and error" in social experimentation. *Id.* at 310. A court can also prevent experimentation by prematurely imposing a constitutional resolution for the entire country regarding a novel and difficult issue at a time when individual states are engaged in testing the unknown or inadequately understood dimensions of this issue.

Assessing the merits and demerits of physician-assisted suicide is, in Justice Brandeis' words, "a formidable task" involving a "multitude of judgments." *Id.* (For a specification of many of the empirical uncertainties regarding this practice, *see* Part II, *infra).* Thus far only one state has directly embarked on this task by resolving to effectuate the practice; implementation of this experiment by the state of Oregon has been blocked by a federal district court's constitutional ruling.

Lee v. Oregon, 891 F. Supp. 1429 (D. Or. 1995) (this ruling was explicitly disapproved in the Ninth Circuit opinion under review here, 79 F.3d at 839 & nn. 138-39). But this impediment should be removed and we would then have the benefit of what Justice Brandeis called "one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." *New State Ice Co.*, 285 U.S. at 311.

B. Regarding Physician-Patient Relations, the Modern Court Has Applied Justice Brandeis' Approach to Avoid Premature Constitutional Resolution of Novel, Factually Complex Issues.

The decision of this Court most directly relevant to the instant case is *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990). *Cruzan* was "the first case in which we have been squarely presented with the issue whether the United States Constitution grants what is in common parlance referred to as a 'right to die.' " *Id.* at 277. In *Cruzan*, the Court effectively endorsed Justice Brandeis' admonition to withhold constitutional resolution in order to promote the development of diverse state approaches. The Court favorably acknowledged the "diversity" of state common-law approaches to the "perplexing question with unusually strong moral and ethical overtones" of withholding life-prolonging medical treatment from incompetent patients. *Id.* The Court observed that a constitutional resolution of this question would wrongfully truncate the range of relevant considerations because of the "simpl[e] and stark" way that the issue would be posed in constitutional adjudication, whereas individual states have a "number of sources" available to them "which are not available to us" in federal constitutional adjudication. *Id.*

Cruzan explicitly acknowledged that the state regulation in that case directly impinged on the exercise of a

constitutionally protected "liberty interest." *Id.* at 278. The Court nevertheless recognized the propriety of diverse state approaches to the issue in light of its complex factual context.[2]

Justice O'Connor made clear in her concurring opinion in *Cruzan* that the Court's deference to diverse state approaches did not mean that no authoritative constitutional resolution would ever be judicially imposed,[3] but only that such a resolution would be premature in light of the novelty and factual complexity of the issue.[4]

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[2] The Court observed, "We follow the judicious counsel of our decision in *Twin City Bank v. Nebeker*, 167 U.S. 196 (1897), where we said that in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.' " 497 U.S. at 277.

[3] Justice O'Connor stated:

> Today's decision, holding only that the Constitution permits a State to require clear and convincing evidence of Nancy Cruzan's desire to have artificial hydration and nutrition withdrawn, does not preclude a future determination that the Constitution requires the States to implement the decisions of a patient's duly appointed surrogate. Nor does it prevent States from developing other approaches for protecting an incompetent individual's liberty interest in refusing medical treatment. As is evident from the Court's survey of state court decisions . . . no national consensus has yet emerged on the best solution for this difficult and sensitive problem. Today we decide only that one State's practice does not violate the Constitution; the more challenging task of crafting appropriate procedures for safeguarding incompetents' liberty interests is entrusted to the "laboratory" of the States, *New State Ice Co. v. Liebmann* . . . (Brandeis, J., dissenting), in the first instance. (497 U.S. at 292).

[4] In another case that also directly impinged on constitutional rights in physician-patient relations, this Court was equally unwilling to impose a "simpl[e] and stark" constitutional rule. In *Whalen v. Roe*, 429 U.S. 589 (1977), the state had required physicians to report the names and addresses of patients for whom they prescribed certain medications and a lower court ruled that this requirement invaded "one of the zones of privacy accorded

(Continued)

C. The Modern Court Has Applied Justice Brandeis' Approach to Promote State Experimentation and Avoid Premature Constitutional Resolution in Many Other Contexts.

In a series of decisions addressing different constitutional provisions, the Court has purposefully withheld constitutional resolution in order both to permit and to promote experimentation by states. The underlying premise of these decisions has been that the experience and knowledge gained in these diverse state efforts would serve to clarify and refine the constitutional issues before any final judgment by this Court.

1. Interpreting the Fourteenth Amendment due process right to a fair trial.

Chandler v. Florida, 449 U.S. 560 (1981), was a constitutional challenge to the state's newly-instituted practice of broadcasting the proceedings of a criminal trial notwithstanding a defendant's objection. The Court ruled that on the facts of the specific case before it, no constitutional violation had been demonstrated. *Id.* at 574. The Court refused, however, to enunciate a general constitutional rule binding for future cases. "It is clear that the general issue of the psychological impact of broadcast coverage upon the participants in a trial, and particularly upon the defendant, is still a subject of sharp debate. . . . Comprehensive empirical data are still not available -- at least on some aspects of the problem." *Id.* at 577. The Court acknowledged that the state's

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constitutional protection" in the doctor-patient relationship. The Supreme Court acknowledged that the state regulation had "some effect on individual liberty or privacy" but nonetheless concluded that "individual States [must] have broad latitude in experimenting with possible solutions to problems of vital local concern." *Id.* at 597.

action might "have an adverse effect" on the "detached atmosphere" necessary to protect a defendant's right to a fair trial. *Id.* at 578. Nonetheless, the Court found that "at present no one has been able to present empirical data sufficient to establish" this proposition, that "further developments and more data are required before this [constitutional] issue can be finally resolved." *Id.* at 578-80 & n. 12.

Notwithstanding the possibility that the continuation of the state policy would infringe on the fair trial right, the Court in *Chandler* clearly ruled that it was premature to resolve the constitutional issues until more experience had accumulated and more empirical data was available for adequate evaluation of the claims presented. The Court observed, "[T]he very broadcast of some trials potentially [may be] a form of punishment in itself -- a punishment before guilt. This concern is far from trivial. But, whether coverage of a few trials will, in practice, be the equivalent of . . . the public pillory long abandoned as a barbaric perversion of decent justice . . . must also await the continuing experimentation." *Id.* at 580-81. Citing "the admonition of Justice Brandeis, dissenting in *New State Ice Co.*," the Court concluded, "This concept of federalism . . . favoring Florida's experiment, must guide our decision." *Id.* at 580.

2. Interpreting the Eighth Amendment right against cruel and unusual punishments.

In several instances the Court has held that it would be premature to impose a uniform constitutional rule in the administration of capital punishment until more state legislatures had acted, more experience had accumulated and more empirical data was available for adequate evaluation of the claims presented. In *Penry v. Lynaugh*, 492 U.S. 302 (1989), the Court considered a constitutional claim that execution of mentally retarded people violated the Eighth Amendment ban against "cruel and unusual punishment." The

Court refused to endorse this constitutional claim but, at the same time, explicitly refused to rule out the possibility that future actions by state legislatures might someday justify the Court's proclamation of such a right.[5]

In a case decided just one year earlier, Justice O'Connor was equally explicit that constitutional judgment should be withheld until state legislatures had independently deliberated on the matter. In *Thompson v. Oklahoma*, 487 U.S. 815 (1988), the Court divided four-to-four on the question whether the Constitution forbade execution of a person under 16 years of age. In her separate opinion which constituted the rule of the case, Justice O'Connor refused to resolve the constitutional question and instead held only that no such juvenile could be executed without explicit statutory prescription by the state legislature. *Id.* at 855. Justice O'Connor concluded that more "careful consideration" on this issue should take place among state legislatures. *Id.*[6]

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5 The Court stated:

> Only one state [Georgia] . . . currently bans execution of retarded persons. . . . Maryland has enacted a similar statute which will take effect [imminently]. . . . [The petitioner] points to several public opinion surveys that indicate strong public opposition to execution of the retarded. . . . The public sentiment expressed in these and other polls and resolutions may ultimately find expression in legislation, which is an objective indicator of contemporary values upon which we can rely. But at present, there is insufficient evidence of a national consensus . . . for us to conclude that it is categorically prohibited by the Eighth Amendment. (492 U.S. at 334-35).

6 Justice O'Connor wrote:

> The day may come when we must decide whether a legislature may deliberately and unequivocally resolve upon a policy authorizing capital punishment for crimes committed at the age of 15. . . . In my view, however, we need not and should not decide the question today. . . .

(Continued)

The Eighth Amendment may appear especially hospitable to such deference to evolving legislative attitudes and experience since it forbids not simply "cruel" but also "unusual" punishments, and the Court has held that legislative actions might themselves be a measure of "unusualness."[7] Nonetheless there is a more fundamental parallel between the jurisprudence of the Eighth and Fourteenth Amendments which establishes the equal relevance of state legislative actions for judicial interpretations of other constitutional provisions.

3. Interpreting Fourteenth Amendment "privacy" or "liberty" interests.

In *Trop v. Dulles*, 356 U.S. 86, 100-01 (1958), the Court stated "that the words of the [Eighth] Amendment are not precise, and that their scope is not static. The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society." This evolutionary conception is precisely the interpretive guide that Justice Harlan identified in his now-classic concurring opinion in *Griswold v. Connecticut*, 381 U.S. 479, 499 (1965), incorporating by reference his dissenting opinion in *Poe v.*

> By leaving open for now the broader Eighth Amendment question . . . , the approach I take allows the ultimate moral issue at stake in the constitutional question to be addressed in the first instances by those best suited to do so, the people's elected representatives. (*Id.* at 855, 858-59).

7 Amicus Curiae believes that in the specific substantive contexts of these cases, the Court erred in refusing to prohibit on constitutional grounds the execution of mentally retarded persons or of minors under sixteen. Amicus relies on these cases only for the jurisprudential proposition that the Court may decline to declare a constitutional right while explicitly holding open the possibility of a future judicial declaration based on further state legislative developments.

Ullman, 367 U.S. 497, 522 (1961) ("Due process has not been reduced to any formula . . . . [I]t has represented the balance which our Nation, built upon postulates of respect for the individual, has struck between that liberty and the demands of organized society . . . having regard to what history teaches are the traditions from which it developed as well as the traditions from which it broke. That tradition is a living thing." 367 U.S. at 542).

In interpreting the Fourteenth Amendment due process guarantee in *Griswold*, it is clear that Justice Harlan gave the same weight to the accumulated actions and experience of state legislatures generally as the Court gave in its interpretations of the Eighth Amendment in *Penry* and *Thompson*. Justice Harlan stated, "[C]onclusive, in my view, is the utter novelty of this enactment. Although the Federal Government and many States have at one time or other had on their books statutes forbidding or regulating the distribution of contraceptives, none . . . has made the use of contraceptives a crime." *Poe v. Ullman*, 367 U.S. at 554 (emphasis in original).

In evaluating the Fourteenth Amendment due process claim advanced in the instant case, the absence of any state legislative endorsement except for the "utter novelty" of the Oregon statute leads to the conclusion that a constitutional right to physician-assisted suicide is not yet supported by a sufficient "national consensus" (*Penry*) or by "evolving standards of decency" (*Trop*) or by "the balance which our Nation . . . has struck between . . . liberty and the demands of organized society" (*Griswold*). The Courts of Appeals' decisions in this case turn Justice Harlan's reasoning upside down: instead of relying on the collective judgments of forty-nine states to support the imposition of a constitutional rule on one, these decisions effectively impose one lone state's judgment on the other forty-nine.

It is also relevant that when this Court invalidated state laws restricting abortion in *Roe v. Wade*, 410 U.S. 113 (1973), abortions were legally available in every state in some circumstances: to save the mother's life in all states, to safeguard the mother's physical or mental health in "about one third of the states" and simply on demand in four states. *See id.* at 139-40 & n. 37. (Indeed, the statutory criteria regarding the mother's physical or mental health were so liberally construed in some states as to virtually amount to a regime of abortion on demand. *See* Kristin Luker, ABORTION AND THE POLITICS OF MOTHERHOOD, 88-95 (1984).) State legislative endorsement of abortion was thus not an "utter novelty" as it currently is for physician-assisted suicide.

II. CONSTITUTIONAL RESOLUTION IS PREMATURE BECAUSE SUBSTANTIAL UNCERTAINTIES EXIST REGARDING THE POSSIBILITY OF DESIGNING EFFECTIVE SAFEGUARDS FOR THE PRACTICE OF PHYSICIAN-ASSISTED SUICIDE.

Both the Second and Ninth Circuit Courts of Appeals insisted that the constitutional right to physician-assisted suicide must only apply to individuals who voluntarily request it, who are mentally competent and who are terminally ill. *See Compassion in Dying v. Washington*, 79 F.3d at 793; *Quill v. Vacco*, 80 F.3d 716, 718 (2d Cir.), *cert. granted*, 135 L. Ed. 2d. 1127 (1996). Both courts acknowledged that states have a legitimate interest in prescribing safeguards to ensure that the practice is strictly limited to volunteering, mentally competent, terminally ill people. *See* 79 F.3d at 832-33; 80 F.3d at 730-31 & n. 4. Both courts assumed that sufficient empirical knowledge and professional experience were currently available on which states might rely in designing such safeguards. 79 F.3d at 826, 831, 833; 80 F.3d at 730-31.

These assumptions about the current preparedness of the states and the medical profession to design effective safeguards are false. For patients who might request physician-assisted suicide, there are considerable practical problems in assuring voluntariness, in both diagnosing and appropriately treating mental incompetence, and in determining terminal prognoses. These problems might be overcome in the future if empirical research is conducted and, in particular, if the new Oregon statute comes into effect and is carefully monitored, and if currently untested changes in medical education and institutional practices are implemented to prepare physicians for this novel, legally-recognized role. But there is no sufficient current basis in practical experience or rigorous empirical research for any confidence that adequate safeguards can be developed. The courts below have no basis for their assumptions that physician-assisted suicide can in practice be appropriately restricted to voluntary, mentally competent, terminally ill people. It is thus clearly premature for the judiciary to declare the existence of a constitutional right to physician-assisted suicide on the premise that this right must extend only to voluntary, mentally competent, terminally ill people.[8]

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[8] Similar difficulties may exist in assuring the voluntariness and mental competence of gravely ill individuals who refuse life-prolonging treatment. But the possible existence of such similarities provides no reason for extending a constitutional right from this narrower context of an individual's liberty interest in resisting unconsented bodily intrusions; the possible similarities provide strong reasons for caution rather than expansive adjudication. This Court, moreover, was appropriately cautious in its consideration of constitutional claims to refuse treatment in *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261 (1990), acting only after this right had been recognized during the preceding fifteen years by some fourteen state appellate court decisions. *Id.* at 277 n. 6. By contrast, only one state supreme court has just recently addressed the question of physician-assisted suicide presented in this case, *People v. Kevorkian*, 447

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A. Voluntariness

1. A dying person suffering from intense pain cannot voluntarily choose suicide unless available, effective pain treatment is offered.

The most powerful and poignant argument on behalf of legalizing physician-assisted suicide is to provide release for terminally ill people from intense, intractable pain. For anyone forced to choose between continued life with such pain and the release of death, the pain obviously exerts an enormous and even overwhelming coercive impact. This impact in itself obviously cannot justify characterizing a choice for death as "involuntary." If, however, this pain is actually avoidable but the suffering individual is neither informed of this fact nor given the opportunity to alleviate this terrible pain, then this individual is not acting voluntarily in choosing death as the only or even the preferred way to end suffering.

Many dying people in this country today are suffering from insufficiently treated pain.[9] Medically effective

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Mich. 436, 527 N.W.2d 714 (1994), *cert. denied sub nom., Hobbins v. Kelley*, 115 S.Ct. 1795 (1995), and refused to find a constitutional right in the context of Jack Kevorkian's ministrations in that state.

[9] How commonly pain marks the actual experience of dying is uncertain, and estimates vary substantially across institutions, whether hospices or hospitals. Coyle et al. reported that three of every four cancer patients had pain. Bonica's review of published reports indicates that more than half of cancer patients have severe pain. Saunders has claimed that one fourth of cancer patients have inadequate pain control when dying.

American Medical Ass'n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 JAMA 474, 475 (1996) (citations omitted) (*hereinafter, Good Care of the Dying Patient*). *See also* C.S. Cleeland, et al., *Pain and Its Treatment in Outpatients with Metastatic Cancer*, 330 N. Eng. J. Med. 592 (1994).

techniques for completely alleviating this pain are available for almost all of these people; according to knowledgeable physicians and researchers, this is possible in as many as ninety-eight percent of cancer cases.[10] But the medical profession generally is neither informing patients of this possibility nor providing this palliative care.[11]

We do not adequately understand the reasons for this failure by the medical profession; nor do we understand how this medical failure can be effectively remedied. There are many possible explanations, such as: insufficient knowledge among physicians about pain management because of inadequate professional training; state and federal legal restrictions on availability of controlled substances for pain

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[10] [O]nly 2% of patients in hospice care experience pain that is difficult for a skilled team to manage. With the exception of one study, other investigators confirm this low rate of serious pain persisting in systems of care that emphasize pain management. The rates of pain in persons who are dying of diseases other than cancer are not [however] well described.

Good Care of the Dying Patient, 275 JAMA at 475 (citations omitted).

[11] The potential for management of pain has recently improved, both through the development of better techniques and through enhanced care delivery through hospice and palliative care efforts. . . . Although guidelines and a curriculum on pain management have been developed, oncologists and others report serious perceived shortcomings in management of cancer pain.

Good Care of the Dying Patient, 275 JAMA at 475. Other distressing symptoms of dying patients, in addition to pain, are also inadequately treated by physicians. *See* Susan Block & Andrew Billings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Arch. Intern. Med. 2039, 2040 (1994) ("Other symptoms [beyond pain] (eg., dyspnea, anorexia, nausea, constipation, insomnia, and anxiety) regularly plague terminally ill patients and are often inadequately controlled by physicians who lack expertise in palliative care or fail to take an aggressive stance toward assuring patient comfort.").

relief and/or physician misconceptions about the legal restrictions; failure even to acknowledge a patient's pain because of unwillingness or inability of physicians and other medical personnel to engage in more than perfunctory conversation, or in many cases any conversation, with patients who are perceived as dying.[12]

The explanation for this failure cannot plausibly be cruelty or callousness of the medical profession; there is widespread acknowledgment and dismay within the profession about our failure to provide even minimally adequate pain palliation for most dying people. But we do not know enough about the causes of this failure to prescribe confidently effective remedies for it.

The most recent and disturbing indication of our ignorance is the research results of the so-called SUPPORT project. This four year study involving nine thousand seriously ill adult patients in five U.S. teaching hospitals was designed "to improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged process of dying." Alfred P. Connors, et al., *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients; The Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments* (SUPPORT), 274 JAMA 1591 (1995). Phase I of the study, to establish the empirical base-line of practices current in 1989-91, documented that overall "50% of all conscious . . . patients who died in the hospital experienced moderate or severe pain at least half the time

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[12] *See* Kathleen Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290-93 (1991); M.B. Max, *Improving Outcomes of Analgesic Treatment: Is Education Enough?* 113 Ann. Int. Med. 885 (1990); J.H. Von Rouenn, et al., *Physician Attitudes and Practice in Cancer Pain Management*, 119 Ann. Int. Med. 121 (1993).

during their last 3 days of life" although there was "substantial variation" among the five hospitals. *Id.* at 1594.[13] In Phase II, conducted in 1992-94, patients were divided into intervention and control groups, with the intervention group receiving intensive services from a "specially trained nurse" who, among other functions, facilitated communication and "encouraged attention to pain control" between the medical care team and patients and their families. 274 JAMA at 1591. Unfortunately, this "phase II intervention failed to improve care or patient outcomes." *Id.* In particular, reports of untreated pain during the last three days of life actually somewhat increased among intervention group patients as compared to control group patients. *Id.* at 1595.

The SUPPORT study was the most comprehensive research on the experience of dying patients ever conducted in this country. The failure of its intervention not simply to correct but even to measurably affect the problem of unnecessary but untreated pain among dying patients is a puzzling result.[14] Amicus curiae, the Project on Death in

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[13] This base-line result was consistent with numerous other prior research reports. *See Cancer Pain Relief and Palliative Care*, 19, World Health Organization (Report of a WHO Expert Committee) (1990).

[14] As the researchers observed:

> The study certainly casts a pall over any claim that, if the health care system is given additional resources for collaborative decision making in the form of skilled professional time, improvements will occur. . . . [T]he overall results of this study are not encouraging. No pattern emerged that implied that the intervention was successful for some set of patients or physicians or that its impact increased over time. The five hospitals had been chosen for their diversity and their willingness to undertake a substantial and controversial challenge. Yet none showed a tendency toward improvement in these outcomes.

274 JAMA at 1596. *See generally Dying Well in the Hospital: The Lessons of SUPPORT*, 25 Hastings Center Report, Special Supp. S1-S36 (1995).

America of the Open Society Institute, is currently supporting the establishment of palliative treatment programs as well as research into the effectiveness of such programs in medical centers throughout the country. We hope that this work will soon demonstrate a considerable improvement of the current, intolerable regime of dying patients suffering unnecessary, treatable pain.

So long, however, as substantial numbers of dying people are unnecessarily suffering from treatable pain, no one can claim that an individual's choice to end his life rather than endure pain is a sufficiently voluntary act. States cannot design adequate safeguards to assure that every suffering person has access to available pain control treatment when we do not yet understand the reasons why such treatment is not being provided to large numbers of patients. Until state authorities, assisted by medical researchers, have understood these reasons and identified effective remedies, judicial pronouncement of a right to physician-assisted suicide, premised on the voluntary character of an individual's choice, would clearly be premature.

It is also possible that, in itself, recognition of a right to physician-assisted suicide would create barriers to the provision of effective pain control and other symptomatic relief to dying patients. This paradoxical result could arise because some pharmacologic measures that are medically necessary to relieve intense pain or other symptoms can also have the unintended effect of hastening death. Even though such measures violate neither legal nor ethical proscriptions, some physicians are currently reluctant to administer adequate palliative medications because of their potential life-shortening effect.[15] If physician-assisted suicide were legalized and

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[15] *See Cancer Pain Relief and Palliative Care*, 52-53, World Health Organization (Report of a WHO Expert Committee) (1990).

accompanied by stringent procedural safeguards, many more physicians might conclude that even their current practices of pain control might require observance of these stringent new procedures. The net result could be the imposition of new barriers to the provision of currently recognized palliative care measures, thus increasing the already large numbers of patients who suffer needlessly from inadequate pain control. This paradoxical result would not inevitably follow from legalized physician-assisted suicide, but carefully designed implementation measures would be required to guard against this possibility. In common, however, with all of the current barriers to inadequate medical provision of palliative measures, we do not yet know enough about the underlying reasons for these barriers in order to design effective remedies to overcome them.

2. Undue financial pressures can undermine the voluntariness of a dying person's choice for suicide.

Prolonged dying from chronic illness, which is the increasingly common mode of death in this country, can be extremely expensive for patients and their families, as well as for private and public health insurers.[16]

Institutional arrangements in the delivery of health care are now in the midst of a fundamental transformation, as increasingly large numbers of patients are choosing, or are being forced by their employers or by state agencies to accept, the provision of medical treatment through managed care organizations. "The most troubling issue for end-of-life care in managed care is the possibility that clinicians are changed from being patients' advocates to having a personal stake in

[16] *See generally* K.E. Covinsky et al., *The Impact of Serious Illness on Patients' Families*, 272 JAMA 1839 (1994).

withholding treatment that would be in the patients' interests." Steven Miles, et al., *End-of-Life Treatment in Managed Care: The Potential and the Peril*, 163 Western J. Med. 302, 304 (1995).[17]

Because the dominance of managed care organizations in American health care is relatively recent, there has been little systematic study of the extent of inappropriate cost-cutting pressures on patients. But if physician-assisted suicide suddenly becomes a constitutionally-sanctioned option for all patients, it is certainly plausible and perhaps even likely that budget-minded health care organization managers and their physician-employees would press their dying patients toward exercising this option.

Perhaps traditional patient-centered medical ethics would guard against this improper pressure; perhaps external regulation of the new health care organizations would adequately protect dying patients against undue influence. But our experience of managed care is too new for any confident claims on this score. And yet, as Judge Reinhardt's opinion for the Ninth Circuit explicitly recognized, without carefully designed safeguards to counteract "the risk of undue influence" for financial gain, a dying person's choice of physician-assisted suicide would not be a truly voluntary act. 79 F.3d at 826.

[17] As Miles, et al. observe:

> Health maintenance organizations (HMOs), preferred provider plans, and managed indemnity insurance cover 80% of the privately insured persons in the United States. Recent large-scale extensions of managed care to public programs of Medicare and Medicaid ensure the continued rapid growth of managed care. The raison d'etre of managed care is to contain the growth of the cost of end-of-life care. About 10% of health care resources are used for the care of persons in their last year of life. (163 Western J. Med. at 302).

Unjustified financial pressures would be even more powerful for the large proportion of the American public without any health insurance, some thirty-seven million according to recent estimates.[18] Once again Judge Reinhardt's opinion noted the problem ("We would be inclined to agree that the country's refusal to provide universal health care, and the concomitant suffering so many Americans are forced to undergo, demonstrates a serious flaw in our national values," 79 F.3d at 826), but nonetheless failed to acknowledge the central relevance of this problem to the constitutional legitimization of physician-assisted suicide. Unless there can be adequate assurances that no person chooses physician-assisted suicide because of poverty, this choice cannot be considered sufficiently voluntary. The judiciary is, however, neither institutionally capable nor constitutionally authorized to create a system to guarantee health care regardless of income.[19] If there should be a right to physician-assisted suicide, it must be accompanied by general recognition of society's obligation to ensure access to adequate health care. The judiciary acting alone cannot achieve this goal.

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[18] *See* Michael Wines & Robert Pear, *Health Costs Pose Problems for Millions, A Study Finds*, N.Y. Times, Oct. 23, 1996, at A18, col. 1.

[19] *See, e.g., San Antonio Independent School Dist. v. Rodriguez*, 411 U.S. 1 (1973) (complex issues regarding equalization of school financing are not amenable to judicial resolution based on a constitutional claim for equal protection); *Dandridge v. Williams*, 397 U.S. 471 (1970) (state welfare law computations of family financial need are not amenable to judicial resolution based on equal protection claims).

B. Mental Competence

1. Judgment-impairing confusion is common among dying persons but is surprisingly difficult to identify as such.

"Confusional states are common" among dying people and, accordingly, "obtaining a truly informed consent is problematic."[20] It might seem self-evident that such confusional states would be readily detected by physicians or even by lay observers such as family members, and requests for assisted suicide would be appropriately disregarded. In actual practice, however, the detection of judgment-impairing confusion among dying people is surprisingly difficult.[21] Based on several studies of dying patients, one researcher concluded that "our clinical observations miss profound confusional episodes in 20 percent of our patients."[22]

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[20] Neil MacDonald, *Suffering and Dying in Cancer Patients: Research Frontiers in Controlling Confusion, Cachexia, and Dyspnea*, 163 Western J. Med. 278, 280 (1995).

[21] Physicians frequently fail to recognize cognitive impairment in hospitalized patients and may miss delirium because of its fluctuating features and subtle presentation. When physician diagnosis is required to identify cases of delirium, reported rates have been quite low. . . . Although physicians diagnosed delirium in only 8 patients, we found 50 patients (22% of the study population) who met criteria for the disorder . . . In this study of elderly patients on medical services, delirium occurred in over one fifth of subjects and was usually evident within 48 hours of admission. Our prospective surveillance identified many more patients with delirium than were seen by psychiatric consultants or diagnosed by physicians.

J. Francis, et al., *A Prospective Study of Delirium in Hospitalized Elderly*, 263 JAMA 1097, 1098, 1100 (1990).

[22] Eduardo Bruera, *Issues of Symptom Control in Patients with Advanced Cancer*, Mar./Apr. 1993, Am. J. Hospice & Palliative Care, 13.

These results are consistent with more general observations in the SUPPORT study about shortcomings in communications between physicians and dying patients. The SUPPORT study found in Phase I that, of the patients who had expressed preferences for withholding cardiopulmonary resuscitation, "only 47% of their physicians accurately reported this preference." 274 JAMA at 1594. In Phase II, for the intervention group in which a specially trained nurse talked with both physicians and patients on a regular basis regarding patient preferences, among other things, the SUPPORT study found essentially no improvement in physicians' understanding of patients' preferences.

It thus appears that dying patients and their physicians are generally reluctant to talk with one another about matters of profound importance ("discussions and decisions substantially in advance of death were uncommon," 274 JAMA at 1595), and that there are substantial misperceptions between physicians and patients when conversations do occur. (These profound silences and miscommunications between physician and dying patients are often mirrored in general doctor-patient interactions. *See generally* Jay Katz, THE SILENT WORLD OF DOCTOR AND PATIENT (1984).)

This pattern of persistently missed communications appears to confirm the finding that physicians and nurses regularly overstate dying patients' decision-making competence. Whatever the reasons, it is clear that state authorities and medical professional groups face a very difficult task, and currently have inadequate experience or research data, in order to design reliable safeguards to ensure the lucidity of dying patients who might claim a right to assisted suicide.

2. Judgment-impairing depression is common among dying persons and, not surprisingly, is difficult to identify as such.

Distinguishing between a dying person's profound sadness and an appropriate psychiatric diagnosis of clinical depression is exceedingly difficult.[23] For many reasons, however, drawing this distinction with accuracy and sensitivity is important in designing appropriate treatment for all dying people in order to provide the greatest possible satisfactions (for conversations, for reconciliations, for good leave-takings) for them and for their families. Identifying clinical depression is even more important when crucial decisions, such as refusing further medical treatment or requesting assisted suicide, are at stake; clinical depression, which commonly carries deep feelings of personal worthlessness and hopelessness, distorts an individual's rational capacity to make choices.

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[23] [D]epression and organic mental disorders are commonly seen among patients who request assistance in dying. These disorders can both impair patient autonomy and coexist with autonomous wishes for hastened death. . . . Determination of competence in this setting is often extraordinarily challenging, requiring subtle evaluations of thought processes and complex assessments of the patient's cognitive understanding, affective and emotional appreciation, and character limitations in understanding the implications of alternative choices.

Susan Block & Andrew Billings, *Patient Requests for Euthanasia and Assisted Suicide in Terminal Illness: The Role of the Psychiatrist*, 36 Psychosomatics 445, 451-2 (1995). *See also* Nathan Cherny, et al., *The Treatment of Suffering When Patients Request Elective Death*, 10 J. Palliative Care 71, 73 (1994) ("Undertreatment [of depression among terminally ill patients] derives largely from the problems of recognition and assessment and from the misconception that depression is a normal response to cancer.").

There has been little systematic research regarding the mental status of dying people who request assisted suicide or refuse life-prolonging treatment. The limited available investigations suggest two propositions: first, that among terminally ill patients "the desire for death could be quite variable over time"; and second, that clinical differentiation between a "psychologically stable" and a distorted decision is "in practice . . . a difficult distinction to make without actually initiating a course of treatment." Harvey Max Chochinov, et al., *Desire for Death in the Terminally Ill*, 152 Am. J. Psychiatry 1185, 1189-90 (1995).

Safeguards could be designed for the administration of physician-assisted suicide to take account of these considerations. It is not clear, however, that the procedures currently followed in the Netherlands -- the only country with any experience of this legally recognized practice -- do give adequate attention to the related issues of temporal instability and the difficulties of accurate psychiatric diagnosis. As Chochinov, et al. observe, "Although the Dutch guidelines are explicit with respect to the requirement that the request for an assisted death must be persistent over time, it has been reported that in practice, 65% of all euthanasia deaths occur within 2 weeks of the initial request" -- a time span which would be too brief to take account of the "temporal instability of the desire for death that was observed in our group" of patients. *Id.* at 1190.

The Ninth Circuit has specified that, consistent with its finding of a constitutional right to physician-assisted suicide, a state may adopt regulations requiring "reasonable, though short, waiting periods to prevent rash decisions." 79 F.3d at 833 (emphasis added). Would that court consider a two-week waiting period too short, just right, or too long to give adequate respect to a dying person's constitutional right to make a voluntary, mentally competent choice for physician-assisted suicide? There is today insufficient practical

experience and empirical research for rendering any confident judgment on the lapse of time necessary to assure that an individual's decision is not "rash" or clouded by depression or other psychiatric illness. This is yet another uncertainty that attends the administration of physician-assisted suicide, and yet another reason that it is premature for courts to take constitutional command of this issue.

C. Prognosis of Terminal Illness

Both of the courts below explicitly limited the constitutional right for assisted suicide to "terminally ill" people. Both courts were confident, moreover, that reliable identification of "terminally ill" people would not be especially difficult. The Second Circuit stated, "[I]t seems clear that most physicians would agree on the definition of 'terminally ill,' at least for the purpose of the relief that plaintiffs seek." 80 F.3d at 731. The Ninth Circuit stated that "the experience of the states has proved that the class of the terminally ill is neither indefinable nor undefined." 79 F.3d at 831.

Both courts are correct that physicians in various contexts are required to determine whether a patient has a "terminal illness." For example, for purposes of admission to hospice programs and eligibility for the Medicare hospice benefit, a patient must be diagnosed as likely to die within six months. There is, however, a substantial degree of uncertainty that attends this prognosis.[24]

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[24] *See* Joanne Lynn, *Caring at the End of Our Lives*, 334 N. Eng. J. Med. 201 (1996). Even though various objective scales for assessing terminal prognoses have been developed in recent years, in order to supplement the more subjective evaluations that individual physicians have always made, it is nevertheless true that all of these judgments remain uncertain. "[T]he pace of dying is affected by many factors over a substantial period of time. . . . Prognosticating will always be inescapably difficult." Joanne Lynn, et

(Continued)

Whatever the justifications for using "terminal illness" predictions in medical decisionmaking, there are special problems that arise when courts use statistical reasoning in determining whether an individual does or does not have a constitutional right. The use of "terminal illness" by the courts below serves to exclude people from exercise of what is held to be a constitutional right.

If a state legislature were to enact such a predictive criterion for excluding people from the exercise of a constitutional right, courts would not hesitate to overturn this restriction on grounds of overinclusive and underinclusive violations of strict scrutiny review. To predict accurately that 100 individuals have a 50% chance of dying within six months, for example, means that in the aggregate 50 of them will die and 50 will not, but it is impossible to determine whether a given individual will be among the living or the dead at the end of the six month period. Accordingly, it is overinclusive to award the constitutional right for choosing assisted suicide to the surviving half of these 100 people. At the same time, the predictive model cannot definitively establish that no one except these 100 individuals with similar

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al., *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 Western J. Med. 250, 251 (1995). "[N]o matter how sophisticated they become, objective probability estimates represent substantial simplifications of very complex systems." William Knaus, et al., *Short-Term Mortality Predictions for Critically Ill Hospitalized Adults: Science and Ethics*, 254 Science 389, 393 (1991). "The [predictive] models produce *probability estimates*. They are developed and validated on large patient populations. . . . They have not been validated for *individual* patient decisions. . . . [W]e are far from achieving the goal of using individual patient level predictors to make difficult and painful decisions regarding . . . critically ill patients." George Thibaut, *The Use of Clinical Models for 'End of Life' Decisionmaking in Critically Ill ICU Patients*, Summary of Committee Views and Workshop Examining the Feasibility of an Institute of Medicine Study of Dying, Decisionmaking, and Appropriate Care, 13:pp.1-3 (1994).

prognostic characteristics will die of a given disease within six months. Accordingly, it is underinclusive to exclude from the constitutional entitlement people with statistically better prognoses who will in fact die during the six-month period.

If courts refrain from proclaiming a constitutional right in this matter, state legislatures could adopt laws restricting physician-assisted suicide to "terminally ill" people without transgressing the mandate of strict scrutiny. The new Oregon enactment does limit its authorization for assisted suicide to adults "suffering from a terminal disease," defined as "an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, produce death within six months." OR. REV. STAT., tit. 13, ch. 127, §§ 2.01, 1.01(12). Courts have held that, in the absence of any infringement on constitutionally protected liberties, such restrictions are valid exercises of legislative authority. *See Williamson v. Lee Optical Co.*, 348 U.S. 483, 489 (1955).

This cautiously incremental methodology is readily available to legislatures but not to courts in constitutional adjudication. A court is not free to pronounce constitutional rights by selecting only "one phase of one field . . . [while] neglecting the others" any more than a legislature would be free to enact arbitrary limits on the availability of court-proclaimed constitutional rights. *Id.* Regarding physician-assisted suicide, moreover, this "one step" for terminally ill people has been taken thus far only by one state. As Justice Brandeis observed in *New State Ice Co.*, "it is one of the happy incidents of the federal system" that this one state can act "without risk to the rest of the country." 285 U.S. at 311.

The very fact that the courts below felt compelled to limit the reach of their proclaimed constitutional right to this inherently imprecise and individually indeterminable category of the "terminally ill" itself demonstrates their implicit understanding that reform in this sensitive and uncertain area

should proceed "one step at a time." The patent unsuitability of this category in constitutional adjudication itself demonstrates that the entire subject-matter of physician-assisted suicide is, at this early moment in public and legislative deliberations about it, not ripe for constitutional resolution.

CONCLUSION

There is no practical experience in any state with the administration of legally recognized physician-assisted suicide, even in the one state where it has only recently been legislatively approved. Although the courts below in the instant cases held that a constitutional right to physician-assisted suicide must be limited only to voluntary, mentally competent, terminally ill people, there are serious questions -- which cannot be answered based on currently available knowledge and experience -- about whether any of these limitations can be adequately determined in practice. Until additional practical experience and systematic research occurs regarding these questions -- in the "laboratories of the states" -- it would be premature to declare whether or not there is a federal constitutional right to physician-assisted suicide. Accordingly, the decisions of the courts below should be reversed on the ground that the issue presented was not ripe for constitutional adjudication.

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IN THE

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DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, *et al.*,
Petitioners,

v.

TIMOTHY E. QUILL, *et al.*,
Respondents,

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

HAROLD GLUCKSBERG, *et al.*,
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On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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36 pp

QUESTIONS PRESENTED

1. Should this Court invent a constitutional right, without support in either constitutional text, history, or tradition, that would prevent a state from prohibiting a person from hiring another to assist in committing suicide?

2. Does the Equal Protection Clause require states to treat identically the act of refusing possibly useless medical treatment or nutrition and hydration and the act of affirmatively requesting and providing assistance for the purpose of intentionally committing suicide?

TABLE OF CONTENTS

QUESTIONS PRESENTED i
TABLE OF AUTHORITIES iii
INTEREST OF AMICUS 1
SUMMARY OF ARGUMENT 2
ARGUMENT 5

I. THE EXISTENTIALIST NOTION OF LIBERTY POSITED IN THIS COURT'S ABORTION JURISPRUDENCE IS FAR TOO SWEEPING TO SERVE AS A GENERAL RULE FOR CONSTITUTIONAL ADJUDICATION AND OUGHT NOT BE EXTENDED TO CREATE A RIGHT TO ASSISTED SUICIDE. 5

A. Neither Constitutional Text, Tradition, nor History Support any Fundamental Right to Assisted Suicide. 5

B. The Definition of "Liberty" Stated in *Planned Parenthood v. Casey* Should Not Be Extended to Create a Right to Assisted Suicide. 9

II. THE STATE MAY RATIONALLY DISTINGUISH BETWEEN ASSISTED SUICIDE AND REFUSAL OF LIFESAVING TREATMENT OR MEDICALLY-ASSISTED NUTRITION AND HYDRATION; THEREFORE, LAWS TREATING THE TWO SITUATIONS DIFFERENTLY DO NOT VIOLATE THE EQUAL PROTECTION CLAUSE. 23

CONCLUSION 28

TABLE OF AUTHORITIES

Page(s)

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Bowers v. Hardwick, 478 U.S. 196 (1986) ... 4, 5, 7, 22, 23

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U.S. CONST. amend. XIV, sec. 1, cl. 3 ..... 10, 13, 28

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BRIEF AMICUS CURIAE OF THE AMERICAN CENTER FOR LAW & JUSTICE SUPPORTING PETITIONERS IN NOS. 95-1858 AND 96-110

INTEREST OF AMICUS

The American Center for Law and Justice ("ACLJ") a national, non-profit, legal organization, and the ACLJ's human life litigation and education project, the New Hope Life Center, are devoted to safeguarding the sanctity of human life through education, litigation, legislative assistance, and related activities, and have advocated for the defense of human life in local, federal, and state courts. The ACLJ's Chief Counsel has argued several cases before this Court, including *Lamb's Chapel v. Center Moriches Union Free School District*, 508 U.S. 384 (1993), *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993), and *Schenck v. Pro-Choice Network*, No.

95-1056 (argued October 16, 1996). In addition, the ACLJ has filed briefs as counsel for parties in several other cases before this Court, including *National Organization for Women, Inc. v. Scheidler*, 510 U.S. 249 (1994), and *Madsen v. Women's Health Center*, 114 S.Ct. 2516 (1996).

The ACLJ files this brief in support of the petitioners in both *Quill* and *Glucksberg* because the courts of appeals' holdings in those cases strike at the heart of the states' long-recognized duty to protect the sanctity of human life. The ACLJ supports the petitioners' contentions in both cases that state laws outlawing assisted suicide are fully consistent with the United States Constitution.*

SUMMARY OF ARGUMENT

1. The Ninth Circuit's decision that Washington's assisted suicide law is unconstitutional because the Due Process Clause creates a right to determine "how and when" to die is dangerously wrong for several reasons. *First*, Washington's law prohibiting assisted suicide rationally furthers the legitimate interest of protecting human life. *Second*, the asserted right has no basis in the Constitution's text or this nation's history and tradition. *Third*, a right to determine "how and when to die" based on the broad, existentialist notion of liberty defined in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), is not susceptible to principled limitation. If liberty is the "right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life" such that the

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*. The parties in both cases have consented to the filing of this brief. Letters of consent are being filed with the Clerk of this Court.

Constitution protects self-defining "intimate and personal choices," *id.* at 851, then liberty must include the right to kill oneself, to have a doctor's or somebody else's help in killing one's self, or to have a doctor or somebody else actually do the killing. All of these involve "intimate and personal choices" concerning a person's "concept of existence." But, if liberty is broad enough to include all these choices concerning how and when to die, then it must be broad enough to encompass many other "intimate and personal decisions." Adopting *Casey's* existentialist notion of liberty as a generally-governing constitutional standard would lead to claims of right to use drugs, and to engage in polygamy, fornication, adultery, divorce, sodomy, bestiality, and consensual sadism. If a person has a constitutional right to have somebody kill him, how can he not have a constitutional right to allow somebody to inflict pain and injury on him?

Casey's existentialist notion of liberty provides no principled basis for distinguishing which of these acts to approve and which to disapprove. Extending that notion of liberty will lead to one of two results: either the courts will require states to approve of much conduct the states may reasonably desire to prohibit as harmful, in effect imposing a constitutionally-mandated moral philosophy on the states; or the courts will arbitrarily pick and choose which activities the states may prohibit, and which activities the states must allow. In effect, the courts will become superlegislatures passing on the wisdom of state laws. This would be a rerun of *Lochner v. New York*, 198 U.S. 45 (1905), which imposed a constitutionally mandatory economic philosophy on the states, and established the courts as the final arbiters concerning the wisdom of state laws touching on "economic liberty."

To avoid these dangers, this Court should either overrule *Casey* or decline to extend *Casey's* definition of liberty. There is good reason to think that *Casey's* authors did not intend a radical extension of *Casey's* definition of liberty to uphold alleged rights like the right to assisted suicide. First, the Court in *Bowers v. Hardwick*, 479 U.S. 186 (1986), rejected a similar notion of liberty put forth to establish a right to commit homosexual sodomy; nothing in *Casey* purports to overrule *Bowers*. Second, the *stare decisis* concerns *Casey* found controlling do not exist in this case. Therefore, this Court should refuse to extend *Casey's* definition of liberty to create a right to assisted suicide.

2. The Washington and New York laws prohibiting assisted suicide do not violate the Equal Protection Clause. Suicide is an act performed for the purpose of causing one's death. By definition, those who are affected by the Washington and New York laws are seeking assistance for the very purpose of killing themselves. Since a state may conclude rationally that suicide is wrong and ought to be prohibited, a blanket prohibition of assisted suicide is rational.

However, persons seeking withdrawal of medical treatment or medically-assisted hydration and nutrition are not necessarily committing suicide. Some are, but many if not most are acting for morally licit reasons – for example, to avoid unduly burdensome or possibly useless bodily intrusions – and only accept death as a known but unintended side effect of that decision. To prohibit all decisions to withdraw medical treatment or medically-assisted hydration and nutrition would further the goal of preventing suicide, but would also sweep in much conduct aimed not at directly causing death but at alleviating needless burdens and suffering, conduct that is not

suicide. A state may rationally conclude that the benefits of preventing suicides outweigh the burdens to those not committing suicide; but the state also could rationally conclude that the burdens outweigh the benefits, and decide not to prohibit withdrawals of medical treatment or medically-assisted hydration and nutrition. Since the state has a rational basis for distinguishing these cases from direct, active, assisted suicide, the state may treat the two situations differently.

ARGUMENT

I. THE EXISTENTIALIST NOTION OF LIBERTY POSITED IN THIS COURT'S ABORTION JURISPRUDENCE IS FAR TOO SWEEPING TO SERVE AS A GENERAL RULE FOR CONSTITUTIONAL ADJUDICATION AND OUGHT NOT BE EXTENDED TO CREATE A RIGHT TO ASSISTED SUICIDE.

A. Neither Constitutional Text, Tradition, nor History Support any Fundamental Right to Assisted Suicide.

Ever since repudiating the substantive due process approach of *Lochner v. New York*, 198 U.S. 45 (1905), this Court generally has limited its review of most state laws under the Due Process Clause to determine only whether those laws rationally serve a legitimate state objective. See, e.g., *Nebbia v. New York*, 291 U.S. 502 (1934); *West Coast Hotel Co. v. Parrish*, 300 U.S. 379 (1937); *Williamson v. Lee Optical Co.*, 348 U.S. 483 (1955); *Bowers v. Hardwick*, 478 U.S. 196 (1986). Certainly, protecting human life is a legitimate government end. That was the view of this nation's founders, who wrote in our founding document that one of the reasons

governments are founded is to secure the "unalienable" right to life. Declaration of Independence, para. 2 (U.S. 1776). Prohibiting assisted suicide rationally furthers this end. Besides helping to preserve the potential suicide's life, a ban on assisted suicide helps to, among other things, "preserve the moral ecology" in a community by preventing bad example which others may emulate, while "educat[ing] people about moral right and wrong" (in this case, the moral "right" of protecting human life and the moral "wrong" of killing). See Gerard V. Bradley, *Pluralistic Perfectionism: A Review of* Making Men Moral, 71 Notre Dame L. Rev. 671, 681 (1996) (reviewing Robert P. George, *Making Men Moral* (1993), and discussing George's argument concerning the legitimate ends served by so-called "morals laws").

Of course, this analysis depends on a state's authority to accept and apply the proposition "suicide is wrong (or harmful)" as a governing proposition for lawmaking. Certainly this proposition is rational (unless one is prepared to dismiss this nation's entire legal history and tradition concerning suicide as irrational). But the respondents in these cases, in effect, seek to deny the states the authority to accept and apply this proposition by positing that the due process clause creates a "fundamental right" to assisted suicide that the state may infringe only upon showing that the infringement is narrowly tailored to serve a "compelling state interest." See *Reno v. Flores*, 507 U.S. 292, 301-03 (1993).

As the Second Circuit correctly observed, the right to suicide, assisted or otherwise, (like the right to "economic liberty" or "freedom of contract" found in *Lochner*) appears nowhere in the Constitution's text. *Quill v. Vacco*, 80 F.3d 716, 723 (2d Cir. 1996). It is true that this Court has granted

heightened protection to "rights" that do not appear in the Constitution's text. The danger in this approach, however, is that it puts the Court in the same position that it occupied during the *Lochner* era–that of a superlegislature substituting its notion of wise public policy for that of the people's elected legislators. Thus, this Court has noted that it "is most vulnerable and comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986); see also *Michael H. v. Gerald D.*, 491 U.S. 110, 122 (1989) (plurality opinion).

Because of this danger, this Court generally "has been reluctant to expand the concept of substantive due process." *Collins v. City of Harker Heights*, 503 U.S. 115, 125 (1992). To limit the proliferation of judge-made rights, this Court has granted heightened protection only to those asserted freedoms that are "'implict in the concept of ordered liberty,' such that 'neither liberty nor justice would exist if [they] were sacrificed.'" *Bowers*, 478 U.S. at 191-92 (quoting *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937)). In determining what asserted freedoms are "implicit in the concept of ordered liberty," the Court generally has turned to history and tradition, according fundamental status only to those asserted freedoms "deeply rooted in this nation's history and tradition." *Id.* at 192 (quoting *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.)); see also *Michael H.*, 491 U.S. at 122 (fundamental liberties are those "traditionally protected by our society"); *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (Due Process Clause grants only those protections "so rooted in the traditions and conscience of our people as to be ranked as fundamental").

This Court's reliance on history and tradition is at bottom an act of profound judicial humility that serves the end of collective self-government. For the Court to assert without fairly explicit textual support that the Constitution affords fundamental protections to activities that the people and their elected legislators historically have restricted or even prohibited would negate the people's authority to govern themselves by laws of their own making.

As the Second Circuit recognized in *Quill,* 80 F.3d at 724-25, and as Justice Scalia demonstrated in his concurring opinion in *Cruzan v. Director, Missouri Department of Health,* 497 U.S. 261, 292-95 (1989), the asserted right to commit suicide, on which the derivative right to assisted suicide depends, flunks the history and tradition test. This brief will not rehash the two cases' discussions. It suffices to say that the English Common Law received in this country prohibited assisted suicide, and the states generally have felt free, both before and after the Fourteenth Amendment's ratification, to prohibit suicide, attempted suicide, and assisted suicide. See *Cruzan*, 497 U.S. at 294-95 (Scalia, J., concurring); *Quill*, 80 F.3d at 724. See generally Thomas Marzen, et al., *Suicide: A Constitutional Right?,* 24 Duq. L. Rev. 1 (1985).[1]

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1. Unlike Justice Scalia in *Cruzan,* the Second Circuit in *Quill*, and the majority of the original panel in *Glucksberg,* the majority of the en banc Ninth Circuit found the historical record "checkered." *Compassion in Dying v. Washington,* 79 F.3d 760, 806 (9th Cir. 1996) (en banc). We leave to the petitioners and other amici the task of refuting in detail the Ninth Circuit's peroration on the philosophical and theological history of suicide in western culture. We note only that the Ninth Circuit's discourse is largely tendentious (particularly in its treatment of Christian teaching about suicide, and most notably its ridiculous assertion that the New Testament treats Judas' suicide as an act of *repentance)* and, in any event, beside the point. Certainly, the Second Circuit in *Quill* was not impressed by Judge Reinhardt's historical scholarship.

B. The Definition of "Liberty" Stated in *Planned Parenthood v. Casey* Should Not be Extended to Create a Right to Assisted Suicide.

That the asserted right to assisted suicide appears nowhere in the Constitution's text and fails the test of history and tradition ought to be a sufficient reason to reject that "right" as one entitled to heightened constitutional protection. The Second Circuit correctly reached that conclusion. See *Quill,* 80 F.3d at 724-25.

Unfortunately, adherence to history and tradition have not always marked this Court's course when deciding to create non-textual constitutional rights entitled to special protection. The primary area in which this Court largely has abandoned its usual caution in creating such rights is the area of abortion. In *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973) this Court overturned all fifty states' abortion laws by finding a right to abortion throughout nine months of pregnancy, despite the fact that neither constitutional text nor our nation's history and tradition supported such a right. *Roe* premised the abortion right on a more general "right to privacy" in childbearing decisions that it culled from earlier cases, particularly, *Griswold v. Connecticut*, 381 U.S. 479 (1965).[2]

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2. Neither *Griswold* nor any of its predecessor cases (for example, *Meyer v. Nebraska*, 262 U.S. 390 (1923), and *Pierce v. Society of Sisters*, 268 U.S. 510 (1925)) support the right created in *Roe*. All those cases were aimed at protecting the integrity of the family *unit,* not some general individual right to make decisions concerning child bearing. *Griswold,* which struck down a Connecticut law prohibiting married couples' *use* of

This Court subsequently reaffirmed what it held to be *Roe's* "central holding" in *Planned Parenthood v. Casey,* 505 U.S. 833 (1992). *Casey* grounded the abortion right on the Due Process Clause guarantee of liberty, see *id.* at 846-53, which it defined in relation to the Court's abortion, contraception, and familial privacy cases as follows:

> Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education. Our cases recognize "the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the right to bear or beget a child." Our precedents "have respected the private realm of family life which the state cannot enter." These matters, *involving the most intimate*

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contraceptives, was premised expressly on the need to protect the privacy that the good of marital intimacy requires, and the damage to that privacy that Connecticut's ban on contraceptive use could do. See 381 U.S. at 484-86 (opinion of the Court); *id.* at 493-96 (Goldberg, J., concurring); *id.* at 507 (White, J., concurring). See also *Poe v. Ullman*, 367 U.S. 497, 553 (1961) (Harlan, J., dissenting). Tellingly, Justice Harlan's dissent in *Poe* distinguished Connecticut's contraceptive ban, which he said unconstitutionally imposed on the goodof marital intimacy, from subjects such as abortion, euthanasia, and suicide, which he said statescould restrict. See *Poe,* 367 U.S. at 545-53 (Harlan, J., concurring). For more extended discussion of the transmogrification of the marital/familial privacy right recognized in *Griswold* into the individual right created in *Roe*, see David M. Smolin, *The Jurisprudence of Privacy in a Splintered Supreme Court* 75 Marq. L. Rev. 975, 1059-64 (1992); Gerard V. Bradley, Life's Dominion: *A Review Essay,* 69 Notre Dame L. Rev. 329, 350-58 (1993); David Wagner, *The Family and American Constitutional Law*, 1 Liberty, Life& Fam. 145,157-67 (1994).

> *and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.*

Id. at 851 (citations omitted; emphasis, except for "*individual*," added).

Casey's conception of liberty formed the linchpin of the Ninth Circuit's decision in *Glucksberg.* The Ninth Circuit en banc majority seized on the italicized language quoted above and concluded that, because "the decision how and when to die 'is one of the most intimate and personal choices a person may make in a lifetime'" that decision "[s]urely...implicates a most vital liberty interest." *Compassion in Dying v. Washington*, 79 F.3d 790, 813-14 (9th Cir. 1996) (en banc). The Ninth Circuit held that no asserted interest justified the state in prohibiting "competent, terminally ill adults" from seeking a physician's assistance in committing suicide. *Id.* at 840.

Admittedly, the Ninth Circuit's extension of *Casey* has a surface logic. If liberty *really* means, as a general constitutional rule, "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," then what the Court recognized in *Casey* is nothing less than a constitutional right to creat[e] one's own moral universe. In fact, the very word "autonomy," which the quoted passage from *Casey* expressly ties to "the liberty protected by the Fourteenth Amendment," 505 U.S. at 851,

"derives from the Greek 'auto' for self and 'nomos' for law, so that it can be literally defined as being a law for, or unto, oneself." David M. Smolin, *The Jurisprudence of Privacy in a Splintered Supreme Court*, 75 Marq. L. Rev. 975, 981 (1992) (citing I *Oxford English Dictionary* 807 (Clarendon Press, 2d ed. 1969)). If *that* is liberty, how can liberty *not* include the right to commit suicide (or as the Ninth Circuit delicately put it, the right to choose "how and when one dies") even with a physician's assistance (or anybody else's assistance, for that matter)?

The Court should resist this logic. *Casey* appears to say that unconstrained choice "define[s] the attributes of personhood." *Casey*, 505 U.S. at 851. If so, then *Casey* has made Jean-Paul Sartre's existentialist philosophy this nation's constitutionally-mandated moral philosophy. The existentialists taught that the human person creates and defines himself by the choices he makes, as summed up in the slogan "existence precedes essence." Jean-Paul Sartre, *Existentialism* 15 (Bernard Frechtman trans., 1947). In other words, choosing is more important than being. Thus, in the existentialist view, "freedom is characterized by a constantly renewed obligation to remake the *Self*," an obligation fulfilled by making self-defining and self-creating choices. Jean-Paul Sartre, *Being and Nothingness* 34-35 (Hazel E. Barnes trans. 1956). See generally Smolin, *The Jurisprudence of Privacy*, 75 Marq. L. Rev. at 980-84.

Of course, the Constitution no more enacts M. Jean-Paul Sartre's *Existentialism* as this nation's governing moral philosophy than it enacted "Mr. Herbert Spencer's Social Statics" as the nation's governing economic philosophy. *Lochner*, 198 U.S. at 75 (Holmes, J., dissenting). In any event,

making *Casey's* existentialist definition of liberty the generally governing constitutional standard would have consequences the *Casey* Court may well not have foreseen. For instance, it reasonably follows from tying "the attributes of personhood" to the ability to "define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," *Casey*, 505 U.S. at 851, that the inability to make this self-definition must be the antithesis of personhood. If so, those without sufficient cognition to make this self-definition are not persons. Since protection under the Fourteenth Amendment's Equal Protection and Due Process Clauses depends on one's status as a "person," the notion that personhood depends on cognition sufficient to allow a being to define his own concept of existence throws considerable doubt on the constitutional status of infants, small children, the mentally retarded, the mentally ill, the mentally incompetent, the comatose, and the unconscious. The joint opinion's notion of personhood as the ability for self-definition through conscious choice echoes the writings of ethicists who have excluded from the ranks of personhood those who lack what the ethicists judge to be sufficient rationality and self-consciousness.[3]

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3. See, e.g., Joseph Fletcher, *Indicators of Humanhood: A Tentative Profile of Man*, 2 Hastings Center Rep. (Nov.1972) (adopting, among other criteria for humanity, self-awareness, ability to communicate, and a minimum IQ of 20, and questioning the humanity of anyonewith an IQ less than 40); Peter Singer, *Practical Ethics* 76, 97 (1979) (proposing that a "person" is a rational and self-conscious being: "So it seems that killing, say a chimpanzee is worse than the killing of a gravely defective human who is not a person"). See generally William Brennan, *Dehumanizing the Vulnerable* 152-56 (1995) (collecting the similar views of other ethicists). See also Bradley, Life's Dominion, 69 Notre Dame L. Rev. at 374-80 (summarizing and critiquing Ronald Dworkin's view of personhood and the

Moreover, a right to assisted suicide based on *Casey's* notion of liberty would be impossible to limit in any principled way. *Glucksberg* and *Quill* concerned the right of "terminally ill" competent adults to receive a physician's assistance in committing suicide. But why limit the right to terminally-ill patients? What of the quadriplegic, consigned to life in a wheelchair? What of the person consigned to suffer lifelong pain from a condition that will not kill him? How much physical suffering and pain are too little to justify a right to suicide? And why are federal courts, including this Court, more competent than the people's elected representatives to make that decision?

An even more basic question arises: If liberty is "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life," why should the assisted suicide right be limited by life expectancy or physical or emotional pain and suffering? "To be, or not to be"[4] would seem to be the fundamental decision *any* person would face in defining his own "concept of existence." If *Casey's* notion of liberty does include the right to define one's own concept of existence, an assisted suicide right based on *Casey* "must be the prerogative of at least every sane adult." *Compassion in Dying v. Washington*, 49 F.3d 586, 591 (1995). See generally Yale Kamisar, *The Reasons So Many People Support Physician-Assisted Suicide–and Why These Reasons are not Convincing*, 12 Issues in Law & Med. 113, 128-30 (1996).

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morality of killing).

4. William Shakespeare, *Hamlet*, act 3, sc.1 (Harvard Classics, Charles W. Elliott ed. 1938).

Moreover, a right to physician-assisted suicide would inevitably become a right to physician-administered voluntary euthanasia in some cases. Even the en banc Ninth Circuit recognized that physicians or their agents might have to actually kill the patient when the patient cannot kill himself. *Compassion in Dying v. Washington*, 79 F.3d 790, 832 (9th Cir. 1996) (en banc).[5] While the Ninth Circuit speculated that the Constitution might treat such voluntary euthanasia differently than physician-assisted suicide, the court candidly acknowledged that the key question is not who kills the patient, but rather who decides to kill. *Id.* at 831-32. This reflects the existentialist notion that the ability to choose consciously is the essence of personhood and liberty. If this notion controls, it would be arbitrary to confine to those who can pull the trigger or administer the deadly potion themselves the right to define their own "concept of existence" by ending that existence. It would be just as arbitrary to confine that right to those who choose to pay a physician to administer the means of death. If the *choice* to die is what matters, how can a court reasonably limit the choice to being killed by a doctor?

This raises the spectre that the Constitution could mandate that the victim's consent be a defense to homicide. The law generally has not regarded consent to be a complete defense to

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5. The Ninth Circuit refused to call this act of killing another "euthanasia," preferring instead to categorize this act along with assisted suicide as "volitional death." See 79 F.3d at 832 & n.120. However, there is no other more proper term for this killing: "euthanasia" *means* "the action of killing an individual for reasons considered merciful." *The American Heritage Dictionary* 469 (2d College ed. 1991). The Ninth Circuit's word play is itself a form of killing–"the murder of a word," which C.S. Lewis called "verbicide." C.S. Lewis, *Studies in Words* 7 (2d ed. 1967).

homicide. See Wayne R. LaFave and Austin W. Scott, *Handbook on Criminal Law* § 57, at 408 (1972). But if doctors are immune from homicide charges for executing a patient's request to be killed, why should not other "angels of mercy" be similarly immune (or at least able to raise consent as a defense at trial)? One might object that such a consent defense would raise evidentiary problems that might not arise when physicians perform voluntary euthanasia. Even if this were true, states could overcome those evidentiary problems by means other than completely prohibiting nonphysicians from performing voluntary euthanasia. Cf. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1989) (upholding a Missouri law requiring "clear and convincing" evidence of an incompetent's wishes before authorizing withdrawal of hydration and nutrition). To ban nonphysicians other than doctors from killing a consenting victim would under the existentialist view arbitrarily limit the ability of a person who cannot afford or does not desire *physician*-assisted death to define his own concept of existence by choosing to end that existence as *he* sees fit.

Connecticut v. Menillo, 423 U.S. 9 (1975) (per curiam), which held that *Roe v. Wade* did not prevent states from enforcing criminal abortion statutes against nonphysicians, is not to the contrary. *Menillo* was premised on the state's interest in preserving maternal health; abortion by physicians is likely to be safer for the mother than abortion by nonphysicians. *Id.* at 10-11. This does not distinguish euthanasia by physicians from killing by nonphysicians. While it may take some medical expertise to perform an operation that kills an unborn child while leaving the mother unharmed (or at least alive), it takes no medical expertise to put a gun to

somebody's head and pull the trigger, or perform the sundry other acts that would kill another.

Some might suggest preventing unnecessary pain as a reason for allowing only doctors to kill. But this aesthetic concern provides no reason to limit a person's right to choose a violent and painful death if that person really has a right to choose "how and when" he dies, *Compassion in Dying*, 79 F.3d at 838, based on a right to define his "own concept of existence, of meaning, of the universe, and of the mystery of human life." Self-loathing is as much a concept of existence and meaning as self-love. One person chooses a painless death; another chooses a painful death; *Casey's* definition of liberty implies that the state is not competent to judge the relative merits of the concepts of existence and meaning that led to those choices.

Finding principled limits to *Casey*-style liberty is not confined to the problem of limiting a right to assisted suicide. Adopting *Casey's* existentialist definition of liberty as a general constitutional standard will inevitably lead to claims of right to engage in sundry other activities besides suicide. These activities could well include drug use, polygamy, fornication, adultery, divorce, prostitution, sodomy, bestiality, and consensual sadism. All these can be said to be "intimate and personal choices" that arise from the person's "concept of existence, of meaning, of the universe, and of the mystery of human life." State prohibitions of these activities would prevent those who would choose to engage in these activities from "defin[ing] the attributes of [their] personhood" as surely as state prohibition of assisted suicide.

Some would scoff at this "parade of horribles." But a "reading of 'the right to define one's own concept of existence'

language broad enough to cover assisted suicide would be broad enough to cover a great many other things. It would surely cover the autonomy of sexual activity and relationships, and it would do so more easily than it would embrace assisted suicide." Yale Kamisar, *Against Assisted Suicide–Even a Very Limited Form*, 72 U. Det. Mercy. L. Rev. 735, 767 (1995).

Take divorce, for example. Certainly, the choice to marry is among "the most intimate and personal choices a person may make in a lifetime." *Casey* 505 U.S. at 851. But the choice to *dissolve* one's marriage also is an intimate and personal choice. Taking *Casey* at its word, and accepting that liberty involves the right to "define the attributes of personhood" by making such choices, a right to divorce necessarily follows. Indeed, Kenneth Karst, applying a supposed right to "intimate association" that is similar if not identical to *Casey's* notion of liberty as the right to unconstrained choice, concluded in 1980 that a constitutional right to no-fault divorce exists. Kenneth L. Karst, *The Freedom of Intimate Association*, 89 Yale L .J. 624, 637-38, 671-72 (1980); see also Smolin, *The Jurisprudence of Privacy*, 75 Marq. L. Rev. at 984 (discussing Karst's theory of intimate association).

As another example, suppose Timmy's "concept of existence, of meaning, of the universe" leads him to conclude that he should "marry" Lassie. If *Casey* meant what it said about liberty, how could the state interfere with Timmy's self-defining choice to pursue this "intimate association"? One might say that our society traditionally has prohibited bestiality. But our society traditionally has prohibited abortion and suicide as well. See Robert M. Byrn, *An American Tragedy: The Supreme Court and Abortion*, 41 Fordham L. Rev. 807, 814-35 (1973) (discussing the history of abortion

prohibition); *Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir. 1996) (discussing historical prohibition of suicide). One might say the state may act to prevent harm to Timmy. But that would be a strange basis for regulating Timmy's conduct with Lassie when Timmy has the right to kill himself or have himself killed.[6] One might say the state may act to prevent harm to Lassie. But that would be an absurd basis for upholding the state's action: the state may prohibit bestiality to prevent harm to animals, but may not prevent humans from harming or even killing themselves (or allowing others to harm or kill them). Moreover, if *Casey's* conception of liberty prevents the state from prohibiting the destruction of a being that is likely a human being, how can that conception of liberty allow a state to prevent a person from having "intimate relations" with a dog?

These examples demonstrate that establishing *Casey's* existentialist definition of liberty as a general constitutional standard could require states to allow conduct the states may well desire to prohibit as harmful, and that the states traditionally have had the authority to prohibit.[7] This, in effect,

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6. This would also seem to preclude prohibitions of consensual sadism. If somebody has the constitutional right to allow another to kill him, on what basis may the state prohibit that person from allowing another to inflict pain on him?

7. *Casey's* notion of liberty may also put in doubt the constitutionalty of such mundane laws as laws requiring automobile passengers to wear seat belts or motorcycle riders to wear helmets, as well as other laws, such as consumer protection laws and FDA regulations, that restrict autonomous choice. *My* concept of meaning requires me to live dangerously; under *Casey*, who is the state to tell me I cannot choose to live dangerously when the state cannot prevent me from intentionally killing myself?

would impose a radical constitutionally-mandated moral philosophy–existentialism–on the states. This is a rerun of *Lochner*, which imposed a constitutionally-mandated economic philosophy on the states. Jean-Paul Sartre's *Existentialism* simply replaces Mr. Herbert Spencer's Social Statics as the Court's mandated philosophy of choice.

Of course, recognizing a right to assisted suicide based on *Casey's* existentialist notion of liberty may not inevitably lead the Court to invalidate laws prohibiting or "unduly" restricting divorce, bestiality, or consensual sadism (or laws prohibiting other consensual activities the law traditionally has prohibited). The Court could reject all these claims or accept some or reject others. It could decide to impose certain "reasonable" conditions on the exercise of choice concerning these matters. But an existentialist notion of liberty as the right to unconstrained choice concerning intimate and personal matters provides no principled grounds for making these decisions. Decisions will necessarily rely on ad hoc and essentially arbitrary judgments: Which decisions are "personal and intimate" enough to fall within *Casey's* definition of liberty? Are some people's concepts "of existence, of meaning, of the universe, and of the mystery of human life" more or less worthy than others? When are the state's or society's interests sufficient to justify constraining choice given the importance the Court sees in the asserted choice?

This ad hoc process would significantly intrude on the people's right to collective self-government. The process would establish the courts as superlegislatures, passing not only on the constitutionality of states' laws, but also–as can be seen from the questions the courts must consider–on those laws' wisdom. Courts, not elected legislators subject to the people's

ultimate control, will decide which laws the people shall be governed by, despite the lack of any express basis for decision in constitutional text or our nation's tradition, and despite the fact that courts are no better situated or qualified to weigh the competing interests at stake.

This is the vice that infected *Lochner's* substantive due process approach. Contrary to popular perception, during the *Lochner* era, "most challenged laws withstood attack." Gerald Gunther, *Constitutional Law* 445 (12th ed. 1991). Yet, *Lochner* represented a significant intrusion on collective self-government precisely by imposing on the states an economic philosophy found nowhere in the Constitution. *Lochner* thus established the courts, and not the states' legislatures, as the ultimate arbiters concerning laws that were reasonable exercises of the states' traditional authority.

To avoid these dangers, the Court should not extend *Casey's* definition of liberty outside the context in which it appeared to create a right to assisted suicide. Of course, one might say that a decision not to so extend *Casey* is itself arbitrary since this Court's abortion jurisprudence suffers from the *Lochner*-style flaws we have just outlined. See generally *Casey*, 505 U.S. at 979-1002 (Scalia, J., dissenting). Therefore, overruling *Casey* would be the most principled way to stanch the dangers that flow from its existentialist notion of liberty. But if the Court is unwilling to overrule *Casey*, "[t]he device of compartmentalizing precedent is an old jurisprudential strategy for limiting unruly doctrines." Kamisar, *Against Assisted Suicide*, 72 U. Det. Mercy L. Rev. at 764. Nothing requires a court to extend bad doctrine further than that doctrine already extends.

In any event, there is good reason to think that the *Casey* joint opinion's authors did not intend for *Casey's* definition of liberty to become a general constitutional standard. As noted, one would expect a definition of liberty as broad as that in *Casey* to encompass the choice to engage in consensual sodomy. In fact, *Casey's* definition of liberty mirrors Justice Blackmun's argument in *Bowers v. Hardwick*, 478 U.S. 186 (1986), that the Constitution protects a person's right to engage in homosexual sodomy. Compare *Casey*, 505 U.S. at 851 with *Bowers*, 478 U.S. at 204-06. See generally Smolin, *The Jurisprudence of Privacy*, 75 Marquette L. Rev. at 981-84. The Court in *Bowers* rejected Justice Blackmun's argument. Yet, nothing in *Casey* purports to overrule *Bowers*.

Moreover, *Casey* expressly relied on the principle of *stare decisis*, as well as the broad definition of liberty, as reasons for affirming *Roe's* "central holding." See 505 U.S. at 853 ("the reservations any of us may have in reaffirming the central holding of *Roe* are outweighed by the explication of individual liberty we have given combined with the force of *stare decisis*"). No previous case of this Court has ever recognized a right to assisted suicide. Therefore, no *stare decisis* concerns exist in this case.[8]

If the Court does not extend *Casey's* definition of liberty, the asserted right to assisted suicide depends for its existence on constitutional text and tradition. As we have shown, neither

8. This is not to say we that agree with *Casey's* application of *stare decisis*, for, in fact, we do not. See, e.g., Jay Alan Sekulow & John Tuskey, *The "Center" is in the Eye of the Beholder*, 40 N.Y. L. Sch. L. Rev. 945, 961-62 (1996). But that does not affect the fact that the *stare decisis* concerns the majority thought controlling in *Casey* do not exist in this case.

text nor tradition support that right. Therefore, the Ninth Circuit's decision creating a right to assisted suicide under the Due Process Clause cannot stand.[9]

II. THE STATE MAY RATIONALLY DISTINGUISH BETWEEN ASSISTED SUICIDE AND REFUSAL OF LIFESAVING TREATMENT OR MEDICALLY-ASSISTED NUTRITION AND HYDRATION; THEREFORE, LAWS TREATING THE TWO SITUATIONS DIFFERENTLY DO NOT VIOLATE THE EQUAL PROTECTION CLAUSE.

The Second Circuit properly rejected the argument that the Due Process Clause creates a right to assisted suicide. *Quill*, 80 F.3d at 724-25. But the Second Circuit held that New York's law prohibiting assisted suicide violated the Equal Protection Clause. *Id.* at 725-31. Essentially, the court found no rational basis for New York to prohibit assisted suicide while allowing withdrawal of life-sustaining treatment and medically-assisted

9. *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) does not require a different result. In *Cruzan*, the Court merely assumed "that the United States Constitution would grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* at 279. Even this assumption was dictum, since *Cruzan* involved an incompetent patient allegedly in a persistent vegetative state. *Id.* at 265. In any event, the Court based its assumption not on any broad existentialist notion of liberty (though such a notion was implicit in the Court's abortion cases, and explicit in Justice Blackmun's *Bowers* dissent, neither of which the Court cited) but rather on cases establishing a person's right to refuse unwanted invasions of his body. See *id.* at 278-79; *id.* at 287-89 (O'Connor, J., concurring). Moreover, in assessing the state's interest in protecting human life, the Court noted approvingly the existence of state laws prohibiting assisted suicide, in no way suggesting such laws might violate the Constitution. *Id.* at 280.

hydration and nutrition. In both cases, according to the Second Circuit, New York allows patients to kill themselves with a doctor's assistance. See *id.*

While the Second Circuit correctly applied rational basis analysis to the New York law because because since neither a fundamental right nor a suspect class are involved in this case, *Heller v. Doe,* 509 U.S. 312, 319 (1993), the Second Circuit erred in both its premise and its conclusion in applying this analysis. Not all (and probably a small minority of) decisions to refuse life-sustaining treatment are suicide; therefore, it is rational to prohibit assisted suicide while at the same time allowing patients to refuse or request withdrawal of life-sustaining treatment.

Suicide is an act performed for the *purpose* of directly causing one's death. But a rational moral distinction exists between suicide and certain acts done with the *knowledge* that death is likely, or even inevitable. For example, a man lying on the railroad tracks waiting for the 9:00 express to put him out of his misery is committing suicide. But a man who sees the train bearing down on his son and rushes onto the tracks to save his son's life knowing full well that he will probably lose his own life in the process is not committing suicide. Nobody would suggest that it is irrational for one who believes suicide is wrong to think of the first act as immoral and the second act as morally permissible.

The people affected by Washington's and New York's assisted suicide prohibitions are by definition seeking assistance for the very purpose of killing themselves. They are, morally speaking, in the first man's position; they are intentionally seeking death. On the premise that suicide is

wrong, no moral gray area exists. Since the state may conclude rationally that suicide is wrong and ought to be prohibited (see *supra*, p.), a blanket prohibition of assisted suicide is rational.

But not all those who refuse or seek withdrawal of medical treatment or medically-assisted nutrition and hydration are intentionally choosing death. Admittedly, some are; but many, if not most people refusing medical treatment "would only be accepting death as a side effect of a choice to give up expensive, possibly useless treatment." Gerard V. Bradley, *Pluralistic Perfectionism: A Review Essay of* Making Men Moral, 71 Notre Dame L. Rev. 671, 684 (1996). This holds even for a decision to refuse medically-assisted nutrition and hydration. As the United States Catholic Bishops noted, "we should not assume that all or most decisions to withhold or withdraw medically assisted nutrition and hydration are attempts to cause death." *Statement of the USCC Committee for Pro-Life Activities*, 24 Origins 705 (1992). As the Bishops recognized, the patient may be facing imminent death anyway, so that his condition, and not lack of nutrition or hydration, will probably kill him; or, the patient may be acting not for the purpose of killing himself, but for the purpose of avoiding a procedure "of limited usefulness to the patient or unreasonably burdensome for the patient and the patient's family or care giver." *Id.*

Those who refuse or seek withdrawal of medical treatment or medically-assisted hydration and nutrition for a reason other than to kill themselves are, morally speaking, in a similar position to the man who ran onto the tracks to save his son, knowing he would likely die in the rescue. They are not committing suicide; they are only accepting death as a side effect of what may well be a morally licit action. See *id.* ("This

kind of decision should not be equated with . . . suicide"). It is entirely consistent with the principle that suicide is wrong to allow these people to refuse medical treatment or medically-assisted hydration and nutrition.

But what of those who refuse medical treatment or medically-assisted hydration and nutrition for the purpose of killing themselves? Admittedly, such refusal would be suicide. But this does not mean that it is irrational for the state to treat all refusals of medical treatment or medically-assisted hydration and nutrition, as a class, differently than it treats assisted suicide by active means.

It makes sense to prohibit all assisted suicides because all who seek assisted suicide are acting specifically to kill themselves. But the question becomes more subtle when speaking of decisions to withdraw life-sustaining treatment or medically-assisted food and hydration because while some people making this decision intend to commit suicide, many if not most people making this decision do not intend to commit suicide; they merely accept death as a side effect of their action. A state operating under the governing principle that suicide is wrong has several possible rational alternatives. The state could prohibit all withdrawal of life-sustaining treatment. This approach would succeed in vindicating the state's conclusion that suicide is wrong and ought to be banned, but at the cost of prohibiting much behavior that is not suicide. One might conclude that given the legitimate interest a person has in refusing unduly burdensome and potentially useless treatment, this cost is too great.

Second, the state could examine each case to determine which withdrawals of treatment really are suicide and which are

not, and restrict or punish those withdrawals that amount to suicide. But error in assessing "what is, after all, the silent operation of the mind," Bradley, *Pluralistic Perfectionism*, 71 Notre Dame L. Rev. at 684, could lead the state to punish acts that really are not illicit killing. This possibility, in turn, could deter the withdrawal of unduly burdensome and potentially useless treatment when such withdrawal would be justified. It would thus be rational for the state to recognize the limited ability of the law and those who must apply the law to make subtle judgments about the subjective reasoning process, and decide not to pursue this case-by-case approach.

Rejecting those first two options, the state could rationally adopt a third option: do not prohibit withdrawal of lifesaving treatment. That would allow some behavior that amounts to suicide. But it would also avoid the cost of prohibiting or deterring morally licit behavior and prevent the law from becoming embroiled in subtle judgments about intent. A rational person could consider the costs of the first two approaches to outweigh their benefits, and thus settle on this third approach as a reasonable resolution.

Thus, a state adhering to the general proposition that suicide is wrong could rationally decide to prohibit assisted suicide and at the same time allow patients to refuse or request withdrawal of life-saving treatment or medically-assisted hydration and nutrition. That decision requires weighing the costs and benefits of alternative courses of action against the states's paramount interest in protecting human life. In short, that decision is quintessentially a legislative decision; it is not the federal courts' domain.

To reject a state's decision in this area would require courts

either to reject the state's right to adopt a mode of moral reasoning that allows one to make distinctions based on the actor's purpose in acting (which would put much established criminal and tort law in constitutional jeopardy) or to reject the state's balancing of the various interests and related costs and benefits involved. Courts would either have to impose a constitutionally-mandated moral philosophy on the states, or courts would have to judge expressly the wisdom of the state's decision. In either event, courts would unduly infringe legitimate state prerogatives and the people's right to collective self-government. *Lochner*-style judicial second guessing would again rear its ugly head, except this time by way of the Equal Protection Clause rather than the Due Process Clause. The Equal Protection Clause does not require this result.

CONCLUSION

For the reason stated above, this Court should reverse both the Ninth Circuit's decision in *Glucksberg* and the Second Circuit's decision in *Quill*.

Respectfully submitted,

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IN THE

Supreme Court of the United States

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DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

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HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

CORRECTED COPY

On Writs of Certiorari to the United States Courts of Appeals for the Second Circuit and for the Ninth Circuit

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BRIEF AMICUS CURIAE FOR THE NATIONAL HOSPICE ORGANIZATION IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Are laws prohibiting physician-assisted suicide justified by legitimate state interests?

TABLE OF CONTENTS

	Page
QUESTION PRESENTED	i
TABLE OF AUTHORITIES	iv
INTEREST OF AMICUS CURIAE	2
SUMMARY OF ARGUMENT	4
ARGUMENT	6
I. THE COURTS BELOW DISMISSED THE STATES' INTEREST IN PRESERVING LIFE BY FAILING TO CONSIDER THE OPPORTUNITIES TO FIND VALUE DURING THE LAST STAGE OF LIFE	6
II. STATES ARE JUSTIFIED IN DISTINGUISHING BETWEEN ASSISTED SUICIDE AND THE WITHDRAWAL OF LIFE-PROLONGING TREATMENT	13
A. Determining How Long a Terminally-Ill Patient Has to Live Is Notoriously Difficult	13
B. Empowering Physicians to End Life Would Irrevocably Change the Way Care Is Perceived and Undermine Hospice Care as a More Appropriate Option for Care of the Terminally Ill	17
CONCLUSION	20

TABLE OF AUTHORITIES

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BRIEF AMICUS CURIAE FOR THE NATIONAL HOSPICE ORGANIZATION IN SUPPORT OF PETITIONERS

INTEREST OF AMICUS CURIAE

The National Hospice Organization ("NHO")[1] is a non-profit, public-benefit, charitable organization dedicated to promoting and maintaining quality care for the needs of terminally-ill persons and their families. Established in 1978, NHO currently represents more than 2,200 hospice programs and 47 state hospice organizations, as well as over 4,000 hospice professionals and supporters.

NHO's organizational mission is to enhance the end of life for people dying in America by ensuring access to quality hospice care. Hospice, in this context, refers not to a place, but rather to a program of care, based on a philosophy that recognizes dying as part of the normal process of living and focuses on enhancing the quality of remaining life. As a central tenet, the hospice philosophy affirms life and seeks neither to hasten nor to postpone death.

A hospice is a coordinated health care program that provides palliative and supportive care to terminally-ill patients and their families, twenty-four hours a day, seven days a week, at home or in home-like facilities. With a focus on enhancing the quality of life for both the patient and the family, hospices provide physical, social, spiritual, and emotional care, using a medically-directed interdisciplinary team consisting of professionals and volunteers. A typical hospice team includes a hospice physician; the patient's attending physician; and one or more nurses, social workers, pastoral or other counselors, home health aides, and volunteers.[2]

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[1] This brief is being filed with the consent of the parties, whose letters of consent have been filed with the Clerk of the Court.

[2] Hospice care is a covered benefit under Medicare, 42 U.S.C. § 1395x(dd), as well as under most other public and private health insurance programs. The Medicare definition of hospice care and conditions of participation for hospice programs form the basis for many state licensure laws and are consistent with NHO's Standards for a Hospice Program of Care.

In order to help patients make the most of the time that remains to them, hospices establish pain control and symptom management as clinical goals. Moreover, hospices understand the need to treat patients' emotional needs as well as their physical requirements and recognize that psychological pain is as significant as physical pain.

Hospices are unique in that they include the patient's family and friends within the unit of care and help family members as an essential part of their mission. Accordingly, hospices provide a wide variety of support for family members and friends while their loved one is dying, as well as bereavement care after the person has died.

The hospice philosophy also affirms the right of those who are dying to make as many choices as possible for themselves—both in living what is left of life and in dealing with fatal illness. An important component of hospice care, therefore, is enhancing the ability of patients to control their lives for as long as possible, even in the terminal phase of their illness. Accordingly, NHO has supported the right of terminally-ill patients to refuse intrusive, life-prolonging treatment or nourishment. Dying patients must have the right to make the choice to refuse interventions designed to prolong the dying process.

NHO does not, however, agree with the courts below that because States must allow terminally-ill people to refuse such unwanted treatments, they must also allow physicians to assist terminally-ill patients to end their lives by suicide. Hospice professionals, who deal with dying patients every day, see these issues as presenting very different risks and benefits to the terminally ill, their families, and society at large.

NHO recognizes that the vast majority of people in this country have strong feelings about issues relating to death. It is a subject affecting us all, and our views are likely to be colored by introspection and fear. It is for that very reason that we must be extremely careful that we use the proper standard for determining the legitimacy of a legislature's conclusions. We should ask ourselves not whether a dying individual has a right, uninhibited by legislative intervention, to choose to have a doctor assist in his suicide, but rather whether the State has a legitimate interest in seeing to it that its citizens be given every opportunity to decide to live, unimpaired by such factors as pain and depression.

It is important, therefore, that this Court be fully aware of a middle ground available between the two extremes of physician-assisted suicide and a death devoid of peace and dignity. In that middle ground is hospice. Without statutes such as those at issue in this case, hospices will have no opportunity to assist persons who simply wish to die become persons wishing to live until they die.

SUMMARY OF ARGUMENT

The decisions below failed to appreciate that the final stage of life presents opportunities for meaningful experiences that could be lost without the State's protection of life and prevention of assisted suicide even among the terminally ill. Moreover, many terminally-ill patients seek assistance with suicide not because they cannot be cured, but rather because they cannot bear the physical pain and depression that often accompany terminal illness. These factors can almost always be ameliorated.

Hospice care provides a proven, effective alternative to assisted suicide that is ideally suited to ameliorate the factors underlying the desire for suicide among the terminally ill. By emphasizing palliative care, the hospice

movement has succeeded in increasing awareness in the medical community of the need to treat pain and symptom management aggressively. Furthermore, hospices understand the psychological dimension of suffering and are committed to treating the depression and fear that surround terminal illness. When patients suffering from terminal illness are given proper palliative and supportive care, the desire for assistance with suicide generally disappears. Hospices provide substantial benefits to the patients' families as well, by including them in the unit of care and by providing them with the counseling, support, and anticipatory grief work that has proven so effective in softening the blow of a loved one's death. Like hospices, States can legitimately place value on the end of life by refusing to support the practice of physician-assisted suicide.

States are also justified in retaining the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment. The medical literature does not support the confidence of the courts below in the ability of medical professionals to distinguish between those who are and are not in the final stages of a terminal illness, and errors in prognosis would have tragic consequences if they were to form the basis for assisted suicide. Abandoning the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment would also thwart recent efforts to increase awareness in both the medical community and the public of the benefits of the comprehensive program of palliative and supportive care offered by hospices. Finally, acceptance of assisted suicide among the terminally ill would place hospices and other health care providers in an untenable position by diminishing the level of trust between the health care provider and patient that is critical to the provision of effective care. Given the adverse consequences that would flow from the recognition of a right to assisted suicide, this Court should adhere

to the traditional distinction between assistance with suicide and the withdrawal of life-prolonging treatment.

ARGUMENT

I. THE COURTS BELOW DISMISSED THE STATES' INTEREST IN PRESERVING LIFE BY FAILING TO CONSIDER THE OPPORTUNITIES TO FIND VALUE DURING THE LAST STAGE OF LIFE.

While recognizing the State's interest in preserving the lives of all its citizens, the courts below found that this interest was attenuated when the lives being preserved suffered from terminal illness. As the Second Circuit reasoned:

> [W]hat interest can the state possibly have in requiring the prolongation of a life that is all but ended? Surely, the state's interest lessens as the potential for life diminishes. And what business is it of the state to require the continuation of agony when the result is imminent and inevitable? * * * The greatly reduced interest of the state in preserving life compels the answer to these questions: "None."

No. 95-1858 Pet. App. 31a (citation omitted). Similarly, the Ninth Circuit found the State's interest in preventing suicides to be "substantially diminished in the case of terminally ill, competent adults who wish to die." No. 96-110 Pet. App. A-73 to A-74. The Ninth Circuit concluded that under such circumstances "the state's interest in preventing such individuals from hastening their deaths [was] of comparatively little weight." *Id.* at A-74; *see also id.* at A-89 (reasoning that the state interest in protecting family members and loved ones "is of almost negligible weight when the patient is terminally ill").

What the courts below failed to recognize is that the final stage of life may be a time of profound opportunity for terminally-ill individuals and their families. The hospice experience has taught that life is not "all but ended" simply because a person suffers from a terminal illness,

nor does "the potential for life diminish[]." Dying is an intrinsic part of being human, and like life's other phases, dying offers unique challenges and opportunities. Given proper support, dying can become an important, valued *life* event. As one commentator has noted, "However diminished the body and however changed the life circumstances in later life, the mind and spirit can still flourish. At all stages of life, even as we are sick and dying, we have the capacity to set new goals, redefine the self, and find valid meaning and integrity in our existence." Nancy J. Osgood, *Assisted Suicide and Older People—A Deadly Combination: Ethical Problems in Permitting Assisted Suicide*, 10 Issues L. & Med. 415, 433 (1995); *see also* Ira R. Byock, *The Nature of Suffering and the Nature of Opportunity at the End of Life*, 12 Clin. Geriatric Med. 237, 248 (1996).

By treating the end of life as meaningless, the courts below adopted an unnecessarily static view that is unable to accommodate the changing nature of life and of the self. Osgood, 10 Issues L. & Med. at 433. Had these courts acknowledged that dying is a part of the normal process of living and that like all of life's stages it presents substantial opportunities for personal growth and development, they would have recognized that the State has an interest in preserving life even in the face of terminal illness. Instead, the courts below adopted a view of dying which admitted only two possibilities: unrelieved misery or assisted suicide. As the Ninth Circuit reasoned, when all that lies ahead is "debilitating pain and a humiliating death, the decision to commit suicide is not senseless." No. 96-110 Pet. App. A-74. This truncated view of dying ignores the fact that it is almost always possible to ameliorate the factors underlying the desire for suicide among the terminally ill.

Numerous studies have documented that uncontrolled pain is a major risk factor for suicide among the terminally ill. *See, e.g.*, Susan D. Block & J. Andrew Bill-

ings, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Archives Internal Med. 2039, 2040 (1994); *see also Physician-Assisted Suicide and Euthanasia in the Netherlands: A Report of Chairman Charles T. Canady to the Subcomm. on the Const. of the House Comm. on the Judiciary*, 104th Cong., 2d Sess. 10 (1996). Sadly, although such physical suffering can almost always be alleviated, until recently physical pain has been woefully undertreated in this country. *See, e.g.*, Block & Billings, 154 Archives Internal Med. at 2040; Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290-293 (1991); Michael H. Levy, *Pharmacologic Treatment of Cancer Pain*, 335 New Eng. J. Med. 1124, 1124 (1996).

Indeed, the undertreatment of pain in terminally-ill patients was one of the factors underlying the development of the first American hospices in the early 1970's. In the intervening decades, however, not only has the hospice movement spread throughout the United States, but, more recently, the organizations that set standards for the practice of medicine have embarked on efforts to educate doctors about palliative care techniques and to encourage appropriate treatment of pain and other symptoms, with the end result that pain should no longer be a cause for ending one's life. Agency for Health Care Policy and Research, *Clinical Practice Guideline No. 9: Management of Cancer Pain* (1994); American Board of Internal Medicine, *Caring for the Dying: Identification and Promotion of Physician Competency—Educational Resources Document* (1996).

Depression is another factor that renders terminally-ill patients vulnerable to thoughts of assisted suicide. *See, e.g.*, William Breitbart *et al., Interest in Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238, 239, 241 (1996); Foley, 6 J.

Pain & Symptom Mgmt. at 294-295; Yale Kamisar, *Are Laws Against Assisted Suicide Unconstitutional?*, Hastings Ctr. Rep., May-June 1993, at 32, 38. When depressed, people lose the ability to compare suicide with alternative solutions or with the prospects for a meaningful future. Thus, victims of depression quickly view their problems as unresolvable and are led to thoughts of escape through death. Furthermore, depression exaggerates the tendency to see the world in black and white terms and encourages the adoption of extreme solutions, such as suicide. Thomas J. Marzen *et al., Suicide: A Constitutional Right?*, 24 Duquesne L. Rev. 1, 119 (1985); Herbert Hendin, *Seduced by Death: Doctors, Patients and the Dutch Cure*, 10 Issues L. & Med. 123, 134 (1994); Osgood, 10 Issues L. & Med. at 428. Such depression is readily treatable, *see, e.g.*, Block & Billings, 154 Archives Internal Med. at 2042; Yeates Conwell & Eric D. Caine, *Rational Suicide and the Right to Die*, 325 New Eng. J. Med. 1100, 1101 (1991), and the typical primary care physician who heretofore has been ill-equipped to recognize treatable depression among the elderly and the terminally ill is now being trained to offer just such relief, *see, e.g.*, Agency for Health Care Policy and Research, *Clinical Practice Guideline No. 5: Depression in Primary Care* (1993).

The treatment of the pain and depression accompanying terminal illness is an important focus of hospice professionals' work. They also deal, however, with a number of other fears associated with terminal illness in the minds of most Americans.[3] An important component of

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[3] At the request of NHO, the Gallup Organization recently surveyed a national sample of Americans on their knowledge and attitudes related to hospice care. One of the questions asked about fears associated with death. While one in seven (14%) mentioned the pain associated with dying, four in ten (40%) said that being a burden to family and friends was their greatest fear. Other fears included lack of control (8%) and losing one's dignity (8%). *The Cutting Edge: Vital Statistics*, Wash. Post, Oct. 8, 1996, at Z5.

a hospice team's role is to help the patient and family understand the progression of the patient's disease, so that changes are not unexpected and plans can be made, increasing the sense of control that is so important to well-being. By training families and other caregivers and supporting them in their care of the patient through respite care and the assistance of volunteers, hospices help to reduce the burden of caring for a dying relative or friend. Through hospice care, families and loved ones may also benefit from interacting with others facing the same predicament. Daryl J. Miller, *Legal Killing: The Imminent Legalization of a Physician's Affirmative Aid-in-Dying*, 34 Santa Clara L. Rev. 663, 703 (1994) (citing Milton D. Heifetz & Charles Mangel, *The Right to Die* 164 (1975)). Counselors may also use this final phase for anticipatory grief work to help prepare for the sense of loss that accompanies the death of a loved one. *Id.*; Elliott J. Rosen, *Families Facing Death: Family Dynamics of Terminal Illness* 97 (1990); J. Eugene Knott & Eugenia Wild, *Anticipatory Grief and Reinvestment, in Loss and Anticipatory Grief* 55, 57-59 (Theresa A. Rando ed., 1986). But most importantly, hospices can allow patients and their families to use the process of dying as an opportunity to resolve outstanding issues. There are countless stories of how families have used life's final stage as the chance to complete social roles and responsibilities, to reconcile previously strained relationships, and to deepen intimate relationships even further. *See, e.g.*, Rosen, *supra*, at 96; Ira Byock, *Dying Well: The Prospect for Growth at the End of Life* (forthcoming 1997) (copy lodged with the Clerk of the Court). As one commentator has noted, "Making the patient whole again and bringing families together at the bedside is what hospice does best." Miller, 34 Santa Clara L. Rev. at 703 (citing Jack M. Zimmerman, *Hospice: Complete Care for the Terminally Ill* 45 (1981)).

The real proof of hospice as a preferable option for care of the terminally ill lies in the results. The evidence demonstrates that when terminally-ill persons who re-

quest assistance with suicide are treated for depression and are given proper palliative and supportive care, they tend to change their minds about assisted suicide. David Cundiff, *Euthanasia Is Not the Answer: A Hospice Physician's View* 23-24 (1992); New York State Task Force on Life and the Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context* 26 (1994); Mark E. Chopko & Michael F. Moses, *Assisted Suicide: Still a Wonderful Life?*, 70 Notre Dame L. Rev. 519, 531-532, 537 (1994); Hendin, 10 Issues L. & Med. at 164; Osgood, 10 Issues L. & Med. at 429. When physical and psychological suffering are succesfully addressed, the patient becomes free to pursue the greatest amount of personal fulfillment possible in his or her remaining life.[4]

In this sense, terminally-ill individuals who seek assistance with suicide are not that different from "the depressed twenty-one year old, the romantically devastated twenty-eight year old, [and] the alcoholic forty-year old" whose

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[4] Dr. Herbert Hendin, Executive Director of the American Suicide Foundation, recounts the story of a patient named Tim who was given a 25% chance of survival and who was referred to Dr. Hendin for psychiatric consultation:

> His immediate reaction was a desperate preoccupation with suicide and a wish for support in carrying it out. At first he could not consider how he felt about death and its meaning to him but remained preoccupied with concerns about being dependent and unwilling to tolerate the symptoms of his disease or the side effects of proposed treatment. Once we could talk about the possibility or likelihood of his dying * * * , his desperate avoidance subsided. He decided to undergo medical treatment, complained relatively little about the unpleasant side effects, and used the remaining months of his life to connect with his wife and parents in ways that were moving and meaningful for him. Two days before he died, Tim talked of what he would have missed without the opportunity for a loving parting.

Hendin, 10 Issues L. & Med. at 128. Similar stories are recounted elsewhere. *See, e.g.*, Marzen, 24 Duquesne. L. Rev. at 132-133; Byock, 12 Clin. Geriatric Med. at 245-246; Byock, *Dying Well*, *supra*.

suicides the Ninth Circuit acknowledged would be senseless. No 96-110 Pet. App. A-74 (internal quotation marks omitted). As that court conceded, "the state has a clear interest in preventing anyone, no matter what age, from taking his own life in a fit of desperation, depression, or loneliness or as a result of any other problem, physical or psychological, which can be significantly ameliorated." *Id.* at A-73. Thus, according to the Ninth Circuit's own logic, the fact that the factors that cause the terminally ill to consider seeking assistance with suicide, such as pain and depression, can be treated is enough to justify the State's prohibition of it. In the vast majority of cases, overturning the state bans on assisted suicide in the name of personal dignity or autonomy, simply because certain people want it, is no more defensible than permitting the depressed twenty-one year old, the romantically devastated twenty-eight year old, and the alcoholic forty-year old to commit suicide. The fact that some people may truly want physicians to help them kill themselves is beside the point. As one commentator noted, "The acceptance of euthanasia for psychiatric patients who are suicidal is simply bad psychiatry. * * * Seriously suicidal patients want suicide. In a society that makes euthanasia accessible for them they will be harder to treat, not easier." Hendin, 10 Issues L. & Med. at 164.

Had the Courts of Appeals understood that "[t]he hospice way of dying * * * offers a middle path between two undesirable approaches in caring for the terminally-ill patient—curative, high-technology medicine on one hand, and death by euthanasia on the other hand," Courtney S. Campbell *et al.*, *Conflicts of Conscience: Hospice and Assisted Suicide*, Hastings Ctr. Rep., May-June 1995, at 36, 37, they never would have felt constrained by the false dichotomy represented by those two options. Hospice offers patients and their families the opportunity to deal with the pain, depression, and other experiences caused

by dying and—unlike the alternative of physician-assisted suicide—gives them the opportunity to continue to live.[5] In light of the availability of hospice care as a means to alleviate the physical and psychological suffering that underlies terminally-ill patients' desire for assistance with suicide and the potential benefits to the patients' families, the States of Washington and New York were more than justified in concluding that their interest in preserving life was just as strong during the last stage of life as it was during all of life's other stages.

II. STATES ARE JUSTIFIED IN DISTINGUISHING BETWEEN ASSISTED SUICIDE AND THE WITHDRAWAL OF LIFE-PROLONGING TREATMENT.

The courts below also erred in challenging the legitimacy of the historical distinction between assistance with suicide and the withdrawal of life-prolonging treatment or nourishment. *See* No. 95-1858 Pet. App. 29a-34a; No. 96-110 Pet. App. A-76 to A-82. In discarding this distinction, the courts below overlooked the legal basis and the practical benefits of this doctrinal line. Moreover, the line that the courts below adopted in place of this distinction—the distinction between terminally ill and non-terminally ill individuals—is fraught with serious practical problems. This Court should adhere to its prior practice of refusing to extend constitutional rights when such an extension would prove unworkable, *see, e.g.*, *United States* v. *Dixon*, 509 U.S. 688, 711 (1993), and reverse the decisions below.

A. Determining How Long a Terminally-Ill Patient Has to Live Is Notoriously Difficult.

The Ninth Circuit's decision hinged on its conclusion that the State's interests in prohibiting assistance with

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[5] As one hospice patient exclaimed, "I went to the hospital to be cured, and almost died. Then I went into Hospice to die, and lived." *See* Warren L. Wheeler, *Hospice Philosophy: An Alternative to Assisted Suicide*, 20 Ohio N.U. L. Rev. 755, 758 (1994).

suicide diminished during "the final stages of an incurable and painful degenerative disease," No. 96-110 Pet. App. A-74, when a patient's "death is imminent," *id.* at A-89.[6] Similarly, the Second Circuit ruled that it was "during the final stages of a terminal illness" when death is "imminent and inevitable" that the State's interest in preserving life abated. No. 95-1858 Pet. App. 31a.[7] Although the Ninth Circuit "acknowledge[d] that it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence," No. 96-110 Pet. App. A-83, the courts below each expressed their confidence in the medical profession's ability to define terminal illness in such a way that would adequately protect patients from the ill effects resulting from errors in medical and legal judgment. *See id.* at A-83, A-103 to A-104; No. 95-1858 Pet. App. 34a.

Medical research, however, has demonstrated the difficulties that surround any determination of how long a terminally-ill patient has to live.[8] As medical researchers have noted, "physicians typically make poor judgments about survival in terminally ill patients." Nicholas A.

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[6] As the Ninth Circuit reasoned, it is only during the final stage of life when patients are "no longer able to pursue liberty or happiness," No. 96-110 Pet. App. A-72, and "can only be maintained in a debilitated and deteriorating state, unable to enjoy the presence of family or friends," *id.* at A-74, that the State's interests in preserving life and preventing suicide recede.

[7] *See also* No. 95-1858 Pet. App. 34a (noting that "[t]he plaintiffs seek to hasten death only where a patient is in the 'final stages' of a 'terminal illness' ").

[8] These problems are compounded by the fact that the legal and medical definitions of the term "terminal illness" vary widely depending on the situation, ranging from a diagnosis of a life-threatening or fatal disease to a prognosis of months or weeks to live. The Medicare statute provides that "[a]n individual is considered to be 'terminally ill' if the individual has a medical prognosis that the individual's life expectancy is 6 months or less." 42 U.S.C. § 1395x(dd)(3)(A).

Christakis & José J. Escarce, *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172, 176 (1996); *see also* Robert A. Pearlman, *Inaccurate Predictions of Life Expectancy: Dilemmas and Opportunities*, 148 Archives Internal Med. 2537, 2537 & nn.2-6 (1988); Howard Brody & Joanne Lynn, *The Physician's Responsibility Under the New Medicare Reimbursement for Hospice Care*, 310 New Eng. J. Med. 920, 921 & nn.3-5 (1984); John F. Potter, *A Challenge for the Hospice Movement*, 302 New Eng. J. Med. 53 (1980). Specifically, assessments of a patient's chances for survival are often biased by the attending physician's recent experiences, which can often lead the physician to overestimate or underestimate the importance of a particular variable. Joanne Lynn *et al.*, *Accurate Prognostications of Death: Opportunities and Challenges for Clinicians*, 163 West J. Med. 250, 251 (1995).

Moreover, the tools of medical prognosis still have yet to account for variations in treatment in an adequate manner. This is particularly problematic because the manner in which the estimate of prognosis necessarily affects treatment options creates a feedback effect that in turn may influence the estimate itself. *Id.* at 256. Such problems are only likely to increase as medical technology continues to improve. Potter, 302 New Eng. J. Med. at 53. Finally, the need for accuracy in such a determination necessarily varies according to the implications surrounding a particular prognosis. Pearlman, 148 Archives Internal Med. at 2537-38. In light of the indeterminacy surrounding the decision as to who is and who is not in the final stages of a terminal illness, the confidence of the courts below in the ability of physicians to apply adequate definitions of terminal illness seems unwarranted.[9]

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[9] In light of these problems, the Ninth Circuit's statement that "should an error actually occur it is likely to benefit the individual by permitting a victim of unmanageable pain and suffering to end his life peacefully and with dignity at the time he deems most

This Court should avoid the practical difficulties surrounding the definition of terminal illness and should instead base its legal principles on the well-established distinction between assistance with suicide and the withdrawal of life-prolonging treatment. The legal support for the right to refuse life-prolonging treatment has been derived by some courts from the right to privacy (the right to be left alone).[10] Others have based this right on liberty interests (freedom from unwarranted state intrusions into bodily integrity). As this Court observed in *Cruzan*, "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from [this Court's] prior decisions."[11] Indeed, "freedom from unwanted medical attention is unquestionably among those principles 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'"[12]

A right to refuse unwarranted invasions of bodily integrity, however, is different from a right to the assistance of a physician in taking one's own life. The first involves protecting oneself against unwanted medical treatment; the second involves enlisting the aid of practitioners to

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desirable" seems puzzling. No. 96-110 Pet. App. A-83. How an erroneous determination of terminal illness that wrongly encourages a patient to seek assistance with suicide inures to the benefit of the patient is far from clear.

[10] *Cruzan ex rel. Cruzan* v. *Director, Missouri Dep't of Health*, 497 U.S. 261, 269 (1990) (citing *Schloendorff* v. *Society of New York Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body * * * .")).

[11] 497 U.S. at 278; *see also id.* at 289 (O'Connor, J., concurring) ("the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment").

[12] *Id.* at 305 (Brennan, J., dissenting) (quoting *Snyder* v. *Massachusetts*, 291 U.S. 97, 105 (1934)).

carry out acts inimical to the physician's purpose and creed. The legal and ethical differences between the two are manifest.

B. Empowering Physicians to End Life Would Irrevocably Change the Way Care Is Perceived and Undermine Hospice Care as a More Appropriate Option for Care of the Terminally Ill.

Ironically, the attempt by the courts below to show sympathy for terminally-ill patients threatens to undercut the ability of hospice care to relieve these patients' suffering. As noted earlier, the medical community has only recently begun to appreciate fully the importance of treating physical and emotional pain and other symptoms aggressively and of providing comprehensive palliative care when cure is not possible. The legalization of assisted suicide would divert attention and support away from these important efforts. *See* Chopko & Moses, 70 Notre Dame L. Rev. at 532; Miller, 34 Santa Clara L. Rev. at 704.

An increased focus on assisted suicide as an option would also impede the growing public awareness of the benefits of hospice care. A recent Gallup poll indicated that fully 82% of adults have heard of hospice care, and 88% would choose hospice-style care if they were terminally ill and had less than six months to live. More importantly, the public, when made aware of the kinds of services provided by hospices, prefers hospice care to assisted suicide. The fact that more people indicated a preference for hospice care in this poll, in which the context suggested hospice as an alternative to suicide, than did so in previous surveys that did not mention hospice care as an option further underscores the influence that ignorance about alternatives to assisted suicide has on public attitudes about care for the terminally ill. *See* Judy Foreman, *70% Would Pick Hospice, Poll Finds*, Boston Globe, Oct. 4, 1996, at A3.

The acceptance of assisted suicide as a way to deal with terminal illness would undercut further efforts to increase the public's awareness of hospice as a life-affirming option.[13] States are justified in prohibiting assisted suicide if for no reason other than to avoid the tragedy of having a terminally-ill patient opt for assisted suicide simply out of ignorance about the alternatives.

Finally, the establishment of a constitutional right to assisted suicide would irrevocably distort the picture of end-of-life care so carefully painted by hospices over the last twenty years. If assistance with suicide gains acceptance, some patients may seek such assistance from hospices, forcing hospices to choose between violating their commitment not to abandon any terminally-ill patient and their commitment neither to hasten nor to prolong death. Worse yet, acceptance of assisted suicide might well lead other patients to reject hospice care for fear that such assistance would be urged upon them.[14]

The courts below clearly erred in equating physician-assisted suicide with the withdrawal of life-sustaining treatment and the relief of pain. It would be tragic if the population at large were similarly confused. Hospices regularly comply with patients' requests to withhold or

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[13] The Netherlands has already witnessed the debilitating effect that tolerance of assisted suicide can have on the hospice movement. Miller, 34 Santa Clara L. Rev. at 663 n.270 (attributing the scarcity of hospices in the Netherlands to "the fact that accepting active euthanasia decreases the incentive to create hospices"); *see also* Wheeler, 20 Ohio N.U. L. Rev. at 760.

[14] People growing older have almost instinctively honed in on the ways that assisted suicide might undermine the care that otherwise would be available to them. A recent survey shows that elderly persons reject physician-assisted suicide, indicating that it is the people most vulnerable to the misuse of physician-assisted suicide who are most strongly opposed to it. Harold G. Koenig *et al.*, *Attitudes of Elderly Patients and Their Families Toward Physician-Assisted Suicide*, 156 Archives Internal Med. 2240, 2248 (1996).

withdraw artificial nutrition and hydration. Hospice physicians also regularly order medications to relieve pain, even when an unintended consequence might be the shortening of a terminally-ill patient's life. As Judge Kleinfeld noted, in labeling the Ninth Circuit's proposition "exactly wrong," "[k]nowledge of an undesired consequence does not imply that the actor intends that consequence." No. 96-110 Pet. App. A-162, A-163 (Kleinfeld, J., dissenting). It is important to hospices that people who approach them during the most difficult times of their lives have no doubt about the intent of the care given them.

Dame Cicely Saunders is the physician who is generally credited with founding the first modern-day hospice, London's St. Christopher's, in 1968. Thousands of hospice professionals and volunteers around the world have repeated her promise to patients: "You matter to the last moment of your life, and we will do all we can, not only to help you die peacefully, but also to live until you die." *See* Sandol Stoddard, *The Hospice Movement: A Better Way of Caring for the Dying* 107 (rev. ed. 1992). The National Hospice Organization asks only that this Court continue to value the lives of terminally-ill patients and that this Court recognize the legitimate interests of States in protecting those lives.

CONCLUSION

For the foregoing reasons, and for those set forth in the petitioners' briefs, the judgments below should be reversed.

Respectfully submitted,

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In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General of the State of New York, GEORGE E. PATAKI, Governor of the State of New York, ROBERT M. MORGENTHAU, District Attorney of New York County,

v.

Petitioners,

TIMOTHY E. QUILL, M.D., SAMUEL C. KLAGSBRUN, M.D., and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

v.

Petitioners,

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

On Writs Of Certiorari To The United States Courts Of Appeals For The Second And Ninth Circuits

BRIEF *AMICI CURIAE* OF AMERICANS FOR DEATH WITH DIGNITY AND THE DEATH WITH DIGNITY EDUCATION CENTER IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Page

INTERESTS OF AMICI 1

INTRODUCTION 2

ARGUMENT 3

I. THE CONSTITUTION PROTECTS THE RIGHT OF A TERMINALLY ILL ADULT TO HASTEN DEATH 4

II. THE RIGHT TO END PERSONAL SUFFERING OUTWEIGHS ANY STATE INTEREST IN PROLONGING THE DYING PROCESS 8

A. The State's Asserted Interests Are Weak ... 8

1. Preservation of Life 9

2. "Erroneous" Deaths 11

3. Abuse, Undue Influence, and the "Slippery Slope." 13

B. State Interests Can Be Protected By Reasonable Regulation 15

C. The Washington Statute Unduly Burdens The Right Of A Mentally Competent Terminally Ill Adult To End Suffering By Hastening Death 17

1. The State's Ban on Physician Aid in Dying Strips Many Terminally Ill Adults of Their Ability to Hasten Death 17

2. The State's Ban on Physician Aid in Dying Can Devastate Terminally Ill People, Their Families, Friends and Physicians 21

CONCLUSION 24

TABLE OF AUTHORITIES

Page

Cases

Bouvia v. Superior Court, 179 Cal. App. 3d 1127 (1986) 20

Brophy v. New England Sinai Hosp., Inc., 497 N.E.2d 626 (Mass. 1986) 9

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) ..... *passim*

Eisenstadt v. Baird, 405 U.S. 438 (1972) 4

Griswold v. Connecticut, 381 U.S. 479 (1965) 4

In re Gardner, 534 A.2d 947 (Me. 1987) 11

In re Guardianship of Grant, 747 P.2d 445 (Wash. 1987), *amended*, 757 P.2d 534 (Wash. 1988) 10

Loving v. Virginia, 388 U.S. 1 (1967) 4, 15

Matter of Quinlan, 355 A.2d 647, *cert. denied sub nom., Garger v. New Jersey*, 429 U.S. 922 (1976) 9

McKay v. Bergstadt, 801 P.2d 617 (Nev. 1990) 10

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992) ..... *passim*

Potter v. Murray City, 760 F.2d 1065 (10th Cir.), *cert. denied*, 474 U.S. 849 (1985) 15

Rasmussen by Mitchell v. Fleming, 741 P.2d 674 (Ariz. 1987) 9

Roe v. Wade, 410 U.S. 113 (1973) 4, 9, 15, 21

Skinner v. Oklahoma, 316 U.S. 535 (1942) 4

Snyder v. Massachusetts, 291 U.S. 97 (1934) 6

TABLE OF AUTHORITIES – Continued

Page

Superintendent of Belchertown State School v. Saikewicz, 370 N.E.2d 417 (Mass. 1977) 9

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250 (1891) 4

Statutes

RCW § 9A.20.020(1)(c) 17

RCW § 9A.36.060 17

RCW § 70.122.010 *et seq.* 6, 11

RCW § 70.122.020(9) 12

RCW § 70.122.040(3) 12

Other Authorities

Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996) 16

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Final Report of the Michigan Commission on Death and Dying, June 8, 1994 16

Sarah Henry, "Whose Life Is it Anyway?" *California Lawyer*, September, 1996 20

TABLE OF AUTHORITIES – Continued

Page

R. Hillier, M.D., *Control of Pain in Terminal Cancer,* British Medical Bulletin (1990) vol. 6, no. 1 at 279 21

Lori Olszewski, *One Man's Choice,* San Francisco Chronicle, Oct. 19, 1992 23

Timothy Quill, *Death and Dignity: Making Choices and Taking Charge* (1993) 7, 22

Robert A. Sedler, *The Constitution and Hastening Inevitable Death,* Hastings Center Report (September-October 1993) 13, 19

INTERESTS OF AMICI*

Americans for Death With Dignity is a California nonprofit corporation. Its constituency, numbering approximately 25,000 persons, includes physicians, clergy, attorneys, terminally ill persons, their friends and families, and others who support the right to physician aid in dying for mentally competent, informed, terminally ill adults.

Americans for Death with Dignity wrote, qualified, and sponsored Proposition 161, an initiative on the November 1992 general election ballot in California. Proposition 161 would have given competent, informed, terminally ill patients the right to request and receive physician aid in dying. Despite a well financed opposition, the measure received 4,562,010 votes, or 46% of the votes cast.

Americans for Death with Dignity believes that a competent, terminally ill adult has a right to choose a peaceful, pain-free and dignified death. For many terminally ill persons, this right cannot be humanely exercised without the aid of a compassionate physician. Americans for Death with Dignity supports reasonable regulation of access to physician aid in dying to ensure that it is not abused.

The Death with Dignity Education Center, based in San Mateo, California, is a national not-for-profit 501(c)(3) organization, founded in 1994. Its mission is to promote a comprehensive, humane, responsive system of care for terminally ill patients.

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*This Brief is filed with consent of all the parties. The letters granting consent are separately lodged.

The Center fosters discussion about physician aid in dying, provides a common meeting ground for dialogue and consensus-building, and develops effective goal-oriented strategies for advancing issues related to end of life care. It serves as an information resource for the public and the media, providing factual, up-to-date information that is balanced, authoritative, and understandable. It extends outreach to established constituencies and professional organizations to encourage them to become involved in the discourse and deliberation surrounding these issues. The Center's goal is to develop the framework for public consensus and the messages that will support it.

INTRODUCTION

How can a competent, terminally ill adult end her suffering and lawfully hasten death in the State of Washington?

> She can take a gun to her head, if she can get it and dares to use it.
>
> If she is lucky enough to be on a life support system she can have a physician disconnect the system and thus die "naturally" by starvation, dehydration or suffocation.
>
> But she can't have a physician prescribe a medication that will bring a quiet, painless and dignified end to her suffering.

The State thus places a higher value on "allow[ing] the disease process to follow a natural course to death,"

Pet. Br. 12,[1] than it does on self-determination, ending suffering and sustaining dignity. That is the crux of the State's position at virtually every step of the argument in this case. The State's view of the Constitution – and, indeed, of life – is cruel, degrading, arbitrary and wrong. The Court should affirm the court of appeals' decision and affirm individual liberty against state power. Anything less would be uncivilized.

ARGUMENT

This case presents one of the great issues of our day: the right of mentally competent, terminally ill adults to exercise their constitutionally protected right of self-determination and individual liberty by hastening death with the assistance of a physician. But, while this issue is great, it is also narrow. Unlike the traditional "suicide" who intends to take his life, the terminally ill person who seeks physician aid in dying does not have the primary goal of ending his life – nature has taken care of that. The person who seeks physician aid in dying wants to end his suffering by shortening the dying *process*. No state has a legitimate interest in prolonging the suffering of the dying.

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[1] Citations to "Pet. Br." refer to the Brief Submitted by Petitioners in *Washington v. Glucksberg*, Case No. 96-110. This brief is filed primarily in response to the arguments made by the State of Washington in the *Glucksberg* case. However, the arguments presented in this brief apply with equal force to the other case before this Court, *Vacco v. Quill*, Case No. 95-1858.

> autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 851 (1992).

Like other "liberty interests," the right of a terminally ill adult to determine the time, place, and manner of her death involves "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Casey*, 505 U.S. at 851. Like a woman who faces an unwanted pregnancy, a terminally ill patient faces "suffering [that] is too intimate and personal for the State to insist, without more, upon its own vision . . . however dominant that vision has been in the course of our history and culture." *Id.* at 852.

Indeed, in *Cruzan* this Court recognized that "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 281 (1990). The *Cruzan* dissenters agreed:

> Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental."

I. THE CONSTITUTION PROTECTS THE RIGHT OF A TERMINALLY ILL ADULT TO HASTEN DEATH.

The constitutionally protected right to self-determination and personal autonomy encompasses the right of a terminally ill adult to end his or her suffering by hastening death with the aid of a physician. The right to self-determination and personal autonomy is imbedded in our nation's tradition. More than a hundred years ago, this Court declared:

> No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.

Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

The Court has relied upon this deeply-rooted right to protect an individual's freedom to decide the course of his or her life. For example, this Court invoked the "liberty interest" to protect the right to procreate, *Skinner v. Oklahoma*, 316 U.S. 535 (1942); to protect personal decisions relating to marriage, *Loving v. Virginia*, 388 U.S. 1 (1967); to protect the rights of both married and unmarried persons to use and have access to contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); and to protect a woman's right to have an abortion. *Roe v. Wade*, 410 U.S. 113 (1973).

The Court stated the principle eloquently in *Casey*:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and

Id. at 343 (Stevens, J., dissenting) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)).

> Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence.

Cruzan, 497 U.S. at 310-11 (Brennan, J., dissenting).

In *Cruzan*, the Court concluded that "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions." *Id.* at 278. Implicit in this statement is the principle that a competent, terminally ill person has a constitutionally protected liberty interest in hastening death, since refusing life-sustaining medical treatment is choosing to die sooner rather than later. In short, this Court in *Cruzan* recognized that a terminally ill patient has a right to hasten death by effectively starving herself to death.

The State not only agrees that such a right exists, Pet. Br. 12, but protects it by statute. RCW § 70.122.010, *et seq.* Accordingly, the State allows a competent, terminally ill person to starve herself to death but does not allow her to ease her way into death by the use of physician-prescribed medication. This position is irrationally cruel, and the State fails to identify any significant difference, in terms of the liberty interest, between these two situations.

Mrs. B's experience aptly illustrates this false dichotomy. At age sixty, Mrs. B had suffered from an aggressive form of breast cancer for ten years. After five years of frequent hospitalizations, surgeries, hormonal therapies, chemotherapy, and radiation, she was rendered bed-

bound and housed in a nursing facility. As she became weaker, and could neither read nor take care of her basic bodily functions, she found her continued "living" unbearable. She turned to her physician for assistance in ending her suffering. After consulting with the hospital ethics committee, the physician outlined the only method by which she could help – Mrs. B would be given intravenous morphine and sedation to leave her unconscious, then be "allowed to die" of dehydration. After saying good-bye to her family and friends, Mrs. B was given the medications intravenously. She lingered for ten days in an unconscious state before succumbing to dehydration. *See* Timothy Quill, *Death and Dignity: Making Choices and Taking Charge* (1993), 111-112.

Moreover, the withdrawal of life-sustaining treatment is no less an *active* step hastening death than the provision of a prescription in response to a competent, terminally ill adult's request. In fact, the act of removing a respirator or withholding life-sustaining nutrition or hydration may be far more intrusive than prescribing medication. When a physician removes a respirator or withholds nutrition or hydration, the patient will die. When a physician prescribes medication, the patient may or may not choose to take the medication. In both instances, it is the patient's wish that operates to hasten death.

Thus, the right of a mentally competent, terminally ill adult to hasten death is a liberty interest protected by the

Due Process Clause from unwarranted governmental interference.[2]

II. THE RIGHT TO END PERSONAL SUFFERING OUTWEIGHS ANY STATE INTEREST IN PROLONGING THE DYING PROCESS.

This liberty interest must be balanced against any competing interests a state might have. *Cruzan*, 497 U.S. at 279. However, the state may not destroy – outright or through restrictions that have the same effect – an individual's ability to exercise his liberty interests. *Casey*, 505 U.S. at 857, 874 ("a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims;" state regulations which impose an "undue burden" on a woman's ability to make the decision to terminate her pregnancy violate the Due Process Clause).

A. The State's Asserted Interests Are Weak.

Although the State asserts a number of interests in banning physician aid in dying, those interests pale in comparison to the interests of the terminally ill people who wish to humanely hasten the dying process.

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[2] Since there is no constitutionally cognizable difference between allowing a person to starve herself to death and allowing a person to hasten death through the use of physician-prescribed drugs, the statute at issue in this case also violates the Equal Protection Clause.

1. Preservation of Life

The State argues that its interest in preserving life outweighs the right of an individual to hasten death with the aid of a physician. Pet. Br. 33-38. This argument ignores a long line of cases, from this Court and others, that recognizes that the state's interest in preservation of life is neither absolute nor static. Rather, the state's interest in preservation of life varies depending on the stage and quality of life at issue.

As various abortion decisions and the "end-of-life" decisions demonstrate, the state's interest in preserving life is strongest in the middle point of the continuum, after viability and throughout an adult's healthy productive years. As an individual approaches death, the state's interest in preservation of life weakens. *See, e.g., Cruzan*, 497 U.S. at 271 (quoting *Superintendent of Belchertown State School v. Saikewicz*, 370 N.E.2d 417, 426 (Mass. 1977)) (state's interest is "greatest when an affliction [is] curable" and less so when " 'the issue is not whether, but when, for how long, and at what cost to the individual [a] life may be briefly extended' "); *Brophy v. New England Sinai Hosp., Inc.* 497 N.E.2d 626, 635 (Mass. 1986) (same); *Roe v. Wade*, 410 U.S. 113, 163 (1973) (describing the state's interest in life as gradually increasing during pregnancy relative to the individual's interest); *Casey*, 505 U.S. at 869 (same); *Matter of Quinlan*, 355 A.2d 647, 663-64 (state's interest in preserving life "weakens and the individual's right to privacy grows as the degree of bodily invasion increases as the prognosis dims"), *cert. denied sub nom., Garger v. New Jersey*, 429 U.S. 922 (1976); *Rasmussen by Mitchell v. Fleming*, 741 P.2d 674, 683 (Ariz. 1987)

(state's interest in preserving life "necessarily weakens and must yield to the patient's interest" where treatment "serves only to prolong a life inflicted with an incurable condition"); *McKay v. Bergstadt*, 801 P.2d 617, 622 (Nev. 1990) ("as the quality of life diminishes because of physical deterioration, the State's interest in preserving life may correspondingly decrease").

At either end of the continuum – before viability and near death – the individual's personal autonomy interest outweighs the state's abstract interest in "preserving life." The terminally ill individuals whose rights are at issue here are at the very end of this continuum, suffering through the final stage of life with no hope of recovery. When a person approaches death and judges continued suffering and degradation to be unbearable, there is no principled state interest in forcing that person, against her will, to prolong the suffering and dying process.[3]

Indeed, the State admits that there is a "well settled" right to hasten death by refusing life-sustaining medical treatment, including refusal of nutrition and hydration. Pet. Br. 12. *See, e.g., In re Guardianship of Grant*, 747 P.2d 445 (Wash. 1987), *amended*, 757 P.2d 534 (Wash. 1988). It apparently believes its interest in preserving life must yield to that right because hastening death through

[3] Similarly, Washington contends that physicians must act only for "therapeutic purposes." Pet. Br. 13. Is it "therapeutic" to prolong life and suffering when death is certain and imminent? Is it therapeutic to remove a patient's food and water to hasten death because of her "physiological inability to chew or swallow," Pet. Br. 38, but not to give that same patient a prescription for medication that will bring a painless and dignified end to her suffering?

refusal of medical treatment "allows the disease process to follow a natural course to death" – which may be "set in motion by [the patient's] physiological inability to chew or swallow." Pet. Br. 38, citing *In re Gardner*, 534 A.2d. 947, 955-56 (Me. 1987).[4]

The State's "preservation of life" rationale thus rests on a cruel and untenable preference for death by starvation or dehydration, which will likely cause suffering for well over a week, over a quick, painless and dignified death through self-administered medication. Surely the Court would not condone such a state preference were this an Eighth Amendment case.

2. "Erroneous" Deaths.

The State also argues that it has an interest in prohibiting "deaths that occur as a result of errors in medical or legal judgment." Pet. Br. 34. Its premise is that "it is sometimes impossible to predict with certainty the duration of a terminally ill patient's remaining existence, just as it is impossible to say for certain whether a borderline individual is or is not mentally competent." Pet. Br. 34.

This argument is disingenuous. Washington, like many other states, has already legislated such issues. The Natural Death Act defines "Terminal condition" as:

[4] Moreover, under Washington law, one need not even be in a persistent vegetative state to refuse nutrition and hydration. *See* RCW § 70.122.010 *et seq.* A fully conscious terminally ill person could lawfully hasten his death by refusing life-sustaining nutrition and hydration.

> an incurable and irreversible condition caused by injury, disease, or illness, that within reasonable medical judgment, will cause death within a reasonable period of time in accordance with accepted medical standards, and where the application of life-sustaining treatment serves only to prolong the process of dying.

RCW § 70.122.020(9). The Legislature recognized that a directive to withhold or withdraw life-sustaining treatment may remain in effect if the declarant "becomes comatose or is rendered incapable of communicating with the attending physician." RCW § 70.122.040(3). Thus, in the context of refusing medical treatment, the Legislature has already come to terms with the issues of defining terminal illness. Those issues are no more complicated in the present context.[5]

The State also pejoratively skews the issue of mental competence. Quoting from a report of the Washington Legislative Council Committee, Dec. 3, 1970, it asserts, "[A potential suicide] is in all probability a troubled, disturbed human being who needs psychiatric care or

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[5] Indeed, if terminally ill adults know that assistance is available, and that they can remain in control of their deaths, that knowledge may actually increase the will to live for many who would otherwise contemplate immediate suicide. "The fear and anxiety that many people feel when contemplating chronic and terminal debilitating illness is rooted, at least in part, in the fear that their suffering will be prolonged by medical technology and that they will have little or no control over its application." Christine K. Cassel, M.D. & Diane E. Meier, M.D., *Morals and Moralism in the Debate Over Euthanasia and Assisted Suicide*, 323 No. 11, New Eng. J. Med., 750, 751 (Sept. 13, 1990).

some other counseling service." Pet. Br. 5. It also characterizes a suicide attempt as "indicative of a mental disorder. . . . " *Id.* at 23. While all this may be true of suicide attempts in the general population, this case deals with the narrow group of mentally competent, terminally ill adults who are already dying. In that context, to request a physician's assistance in hastening death is rational, not remotely "indicative of a mental disorder."

If the State wants to engage in definitional quibbles, it should recall that the statute makes a criminal of one who "aids a suicide." But is honoring a choice to end suffering and indignity by hastening an imminent death "aiding suicide"? Is that more like "suicide" than choosing to suffocate by having a respirator removed? And is removing that respirator – an act expressly sanctioned by the State – something less than "aiding"?

In fact, these "definitional" problems are paper tigers. "In the real world we have no difficulty identifying and distinguishing the terminally ill. They are patients who will die from a specific disease within a relatively short period of time." Robert A. Sedler, *The Constitution and Hastening Inevitable Death*, Hastings Center Report (September-October 1993) at 22. *Accord Casey*, 505 U.S. at 869 ("Liberty must not be extinguished for want of a line that is clear.").

3. Abuse, Undue Influence, and the "Slippery Slope."

The State also raises the specter of abuse and undue influence. Pet. Br. 34. But, the same argument could be (and was) made in the abortion context, or, indeed, any

time an individual has a choice. The alleged risk here is no different than any risk associated with the refusal or withdrawal of life support. Even if there were a risk, the solution is not to eliminate individual choice and place absolute power in the hands of the state. The possibility of malicious third parties influencing the decision to hasten death does not nullify constitutional liberty interests.

The State further claims that affirming the constitutional right to physician aid in dying would "freeze the process of experimentation" and "forestall the opportunity to learn." Pet. Br. 49. Just the opposite is true. As the law currently stands, physician aid in dying is practiced covertly, outside of public scrutiny or discussion, and is more likely to be subject to abuse than if the practice were regulated by the state. Affirmation of the right to physician aid in dying would make the practice subject to reasonable regulations crafted to ensure that access to physician aid in dying is truly in the public interest and is not subject to abuse.

Similarly, the State and some of their *amici* warn that recognition of a liberty interest in physician aid in dying will necessarily result in people's lives being taken against their will. The State falls prey to the "slippery slope" because it refuses to focus on the specific and narrow group whose interests are at issue in this case – competent, terminally ill adults. Although the State may have a justifiable interest in ensuring that the lives of individuals are not taken against their will, that interest

has nothing to do with the right of competent, terminally ill individuals to voluntarily hasten death.[6]

B. State Interests Can Be Protected By Reasonable Regulation.

The State's absolute ban is not necessary to protect any lingering state interests. The alleged dangers of fraud, abuse, or error are avoidable through reasonable regulation of the right to receive aid in dying. As this Court recognized in *Casey*, "not every law which makes a right more difficult is, *ipso facto*, an infringement of that right." 505 U.S. at 873. Indeed, this Court has repeatedly recognized that constitutionally protected liberty interests may be subject to reasonable regulation. *See Loving v. Virgina*, 388 U.S. 1 (the right to marry is a protected liberty interest) and *Potter v. Murray City*, 760 F.2d 1065 (10th Cir.), *cert. denied*, 474 U.S. 849 (1985) (the government may bar polygamy); *Roe v. Wade*, 410 U.S. 113 (women have a constitutionally protected right to decide whether to carry a child to term) and *Casey*, 505 U.S. 833 (the state may impose certain restrictions on access to abortions). Here, regulated physician assisted death would provide protocols and safeguards missing in the present, covert, unregulated context.

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[6] Contrary to the concerns of some *amici*, recognition of a liberty interest in physician aid in dying does not mean that every medical professional will be required to assist every such patient who seeks assistance. Indeed, precisely because life and death decisions are so profoundly personal, such a requirement would arguably trespass upon the physician's own liberty interests.

Several models for regulation of access to aid in dying have been proposed. For instance, the Michigan Commission on Death and Dying, composed of members from all sections of the legal, medical and lay community, formulated a proposal that would permit terminally ill, competent people to seek aid in dying under tightly controlled circumstances. *Final Report of the Michigan Commission on Death and Dying*, June 8, 1994.[7] Under this approach, physician aid in dying would be available to a terminally ill person who made a recorded request for assistance in dying. The request would have to be reiterated to a physician and witnessed two more times, with at least seven days elapsing between the reiterations. Only the terminally ill individual could make the request, and no one else could influence or determine the timing of the assistance if it was given. *Final Report*, Section III, 3. The proposal also calls for psychological and spiritual counseling, aggressive pain management and counseling on independent living alternatives before an eligible person is permitted to act on his or her request to receive aid in dying. *See also* Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996) (imposing similar conditions to safeguard against misuse or abuse, including waiting period, corroboration, professional consultation, documentation and monitoring requirements).

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[7] The Michigan Commission produced three reports with different recommendations; none of the recommendations was endorsed by a majority of the members of the Commission.

C. The Washington Statute Unduly Burdens The Right Of A Mentally Competent Terminally Ill Adult To End Suffering By Hastening Death.

1. The State's Ban on Physician Aid in Dying Strips Many Terminally Ill Adults of Their Ability to Hasten Death.

The Washington statute prohibits physicians from assisting mentally competent, terminally ill individuals to hasten death.[8] Under the statute, a physician cannot prescribe medication to a terminally ill patient if the physician knows that the medication will be used to end the patient's life. While terminally ill people may be able, legally,[9] to hasten death through other means (by shooting themselves, for example), most terminally ill people are confined to institutions and do not have access to those means, are too weak to use them, or are averse to the violence these means often entail. Worse yet, the legal options currently available to the terminally ill are far less humane than the administration of medication that will hasten death.

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[8] The Washington statute states, "A person is guilty of promoting a suicide attempt when he knowingly causes or aids another person to attempt suicide." RCW 9A.36.060(1). Violation of this law is punishable by imprisonment for up to five years and by a maximum fine of $10,000. RCW 9A.36.060(2) and RCW 9A.20.020(1)(c).

[9] The act of suicide is not illegal in any state. *See* Maria T. CeloCruz, *Aid-in-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 377 (1992). Only the act of assisting suicide is illegal.

Changes in medical technology and in the way that Americans die are important factors in the analysis of an individual's right to die:

> "[T]he timing of death – once a matter of fate – is now a matter of human choice." . . . Of the approximately 2 million people who die each year, 80% die in hospitals and long-term care institutions, and perhaps 70% of those after a decision to forgo life-sustaining treatment has been made. Nearly every death involves a decision whether to undertake some medical procedure that could prolong the process of dying. Such decisions are difficult and personal. They must be made on the basis of individual values, informed by medical realities, yet within a framework governed by law. The role of the courts is confined to defining that framework, delineating the ways in which government may and may not participate in such decisions.

Cruzan, 497 U.S. at 302-03 (Brennan, J., dissenting) (citations and footnotes omitted). Similarly, "[p]eople are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions." *Id.* at 339-40 (Stevens, J., dissenting).

Today, 80% of Americans – the vast majority of us – die in hospitals or long term care facilities, in many cases with little or no control over the end of our own lives. When we enter a hospital for the last time, we may have the strength, and technically, the legal right to end our lives if we wish. But once in the medical system, we often

lose the ability to help ourselves. Most of us have neither the knowledge nor the means to end our own lives in an acceptable way. We can't get life-ending substances for a dignified death, even if we knew how to use them. Thus, as a practical matter, competent terminally ill individuals frequently cannot exercise their right to hasten death without the assistance of a physician.

> To say the least, a ban on the use of physician-prescribed medications obviously places a substantial obstacle in the path of a terminally ill person seeking to hasten that person's inevitable death. Indeed, a more extreme burden on the exercise of that right cannot be imagined, and for this reason . . . the ban on the use of physician-prescribed medications is unconstitutional.

Sedler, *The Constitution and Hastening Inevitable Death* at 23.

The continuing criminalization of physician aid in dying hurts patients and their families and inhibits compassionate physicians from helping patients even when they are unable to cure their illnesses. The State insists on comparing a humane medical procedure to murder. Pet. Br. 6, 11 (assisted suicide laws "are generally considered part of the State's homicide laws . . . "; "[O]ne who intentionally acts to cause or contribute to another's death is with rare exceptions guilty of criminal conduct."). Thus the present system condemns dying people who cannot bear their pain any longer and makes closet felons out of compassionate doctors who respond to the last-resort requests of their suffering patients. One oncologist who repeatedly faced this dilemma stated:

> There are cases that stand out in my mind – more than ten – where I was helpless to relieve my patient's suffering, despite aggressive treatment. It made me feel awful. . . . Some of them made requests like "Put me out of my misery." Legally I couldn't do that. . . . I felt that I was abandoning them, but my hands were tied.

Sarah Henry, "Whose Life Is It, Anyway"? *California Lawyer*, September, 1996 at 32.

If the constitutionally protected right to hasten death is to have any meaning, it must include the right to physician assistance:

> The right to die is an integral part of our right to control our own destinies so long as the rights of others are not affected. The right should . . . include the ability to enlist assistance from others, including the medical profession, in making death as painless and quick as possible. . . . If there is a time when we ought to be able to get the "government off our backs" it is when we face death – either by choice or otherwise.

Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1147-1148 (1986) (Compton, J., concurring).

The right of a competent, terminally ill person to physician assistance in dying is supported by constitutional jurisprudence and required by the reality of our modern world. To deny that right is to deny the most basic opportunity for self-determination.

2. The State's Ban on Physician Aid in Dying Can Devastate Terminally Ill People, Their Families, Friends and Physicians.

Under the current law, terminally ill patients who wish to hasten death are left with few options: (1) they can take their own lives through violent means, or (2) they can enlist the aid of friends and family members who may later be subject to criminal sanction.[10] This categorical ban on physician aid in dying only leads to greater suffering for the terminally ill and devastating consequences for family and friends. Like the back-alley abortions prevalent before *Roe v. Wade*, the State's categorical ban on physician aid in dying has not stopped terminally ill people from hastening death; it has merely forced them to choose violent and painful means of ending their suffering because no other options are available.

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[10] The assertion that pain can be controlled in most cases adds nothing. First, it says nothing about those terminally ill persons whose pain cannot be "controlled," and it is precisely these people for whom this case is perhaps most important. Second, it ignores the fact that pain control, in some instances, is achieved only with significant side effects such as confusion, hallucination, nausea, vomiting, constipation and respiratory depression. R. Hillier, M.D., *Control of Pain in Terminal Cancer*, British Medical Bulletin (1990) vol. 6, no. 1 at 279-91. To many, a choice between unbearable pain and loss of mental alertness may be no choice at all. "Living" under either condition may not be within the purview of what makes life worth living. Third, controlling pain is no answer for other kinds of suffering – the loss of dignity that may result from immobility, the inability to speak or swallow, incontinence, and the need for 24-hour-a-day care – that often motivate competent, terminally ill adults to seek physician assistance in hastening death.

> Self-inflicted gunshot, hanging, and asphyxiation all occur, though they may require more strength and energy than many terminally ill patients possess. If successful, patients who use these means to end their lives at least put an end (if gruesome) to their suffering. The victims more often are the families, who may both literally and figuratively have to pick up the pieces.

Quill, *Death and Dignity: Making Choices and Taking Charge*, 114.

Although the State refers to dying, suffering persons as "hypothetical people," Pet. Br. 10, 39, 40, there is nothing hypothetical about the dying people who originally brought this suit. Nor is there anything hypothetical about Bill, an energetic man in his mid-70s, who was dying from throat cancer. After 18 months of treatment, the tumor had spread to Bill's brain and sinuses and Bill had permanently lost most of his hearing, could not swallow solid foods or liquids, had constant headaches, and the drainage from his nose was so severe that he had to wear a pad. After two years of progressive deterioration and indignity, Bill decided to take his life. Since he did not want to subject his friends and family to criminal sanction, he shot himself in the head. After hearing the gunshot, Bill's wife found him, horribly wounded, but still alive. Bill died at the hospital three hours later. *See* Quill, *Death and Dignity: Making Choices and Taking Charge*, 117-120.

Moreover, terminally ill individuals who are determined to end their suffering frequently turn for help to friends or family members who may be subject to criminal sanctions. Another typical example is the story of

Steven who, just shy of his 40th birthday, was dying of AIDS. He enlisted the assistance of an HIV-positive friend. On the appointed night, Steven threw a wake party which was attended by many supportive friends and family. But the plan Steven and his friend had agreed upon went awry. Steven's friend got drunk and became increasingly distraught. When the friend nonetheless began to honor his commitment to Steven, he was interrupted mid-injection by someone and promptly left the house. Those remaining at the party were forced to call a physician who reluctantly told them how to complete Steven's directive. They all faced the risk of criminal liability. *See* Lori Olszewski, *One Man's Choice*, San Francisco Chronicle, Oct. 19, 1992.

The stories of Bill and Steven are not hypothetical or unique, and they did not have to happen. If Bill and Steven had been able to request the assistance of a physician, they could have ended their lives painlessly, with dignity, and without jeopardizing their loved ones. Despite the state's generalized interests in the "preservation of life," the state had no interest in prolonging the dying process for either of these men. Bill and Steven were not abstractions. They were people who had a right to determine how they would die. As Justice Stevens stated in *Cruzan*, 497 U.S. at 356-57 (Stevens, J., dissenting):

> However commendable may be the State's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes. Lives do not exist in

> abstraction from persons, and to pretend otherwise is not to honor but to desecrate the State's responsibility for protecting life.

Physician aid in dying for mentally competent terminally ill adults lets dying people be treated as individuals and not as abstractions. No state has a paramount interest in prolonging the suffering of a terminally ill adult who has competently made the decision to end the dying process.

CONCLUSION

The decision of the United States Court of Appeals for the Ninth Circuit should be affirmed.

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Respectfully submitted,

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OCTOBER TERM, 1996

DENNIS C. VACCO, ATTORNEY GENERAL OF THE STATE OF NEW YORK, *et al.*,

PETITIONERS,

v.

TIMOTHY E. QUILL, M.D., *et al.*,

RESPONDENTS.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

STATE OF WASHINGTON, *et al.*,

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HAROLD GLUCKSBERG, M.D., *et al.*,

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TABLE OF CONTENTS

	Page
TABLE OF CONTENTS	i
TABLE OF AUTHORITIES	ii
INTEREST OF THE AMICI CURIAE	1
SUMMARY OF THE ARGUMENT	2
ARGUMENT	4
THE STATE REGIMES OF REGULATION OVERTURNED BY THE LOWER COURTS ARE UNCONSTITUTIONAL BECAUSE THEY HAVE BECOME IRRATIONAL MEANS FOR ADVANCING THE STATE INTERESTS THAT ARE ALLEGED TO JUSTIFY THEM	4
A. The current regimes no longer make any rational use of the distinction between physician-assisted suicide and refusal of life-prolonging treatment	5
B. By seeking to maintain a broad legal distinction between physician-assisted suicide and refusal of life-prolonging treatment, the current regimes have placed patients at a heightened risk of abuse.	16
1) The current regimes, which encourage the widespread, covert practice of physician-assisted suicide, leave that practice totally without oversight and regulation	16
2) The current regimes, which take decisions to "let patients die" less seriously than decisions to assist suicide, leave the former decisions without adequate oversight and regulation	19
C. Important interests, including respect for law and the rule of law, will suffer if this Court permits reinstatement of the irrational legislative regimes at issue here	25
CONCLUSION	27

TABLE OF AUTHORITIES

Cases Page

Allegheny Pittsburgh Coal Co. v. *County Comm'n of Webster County, W. Va.*, 488 U.S. 336 (1989) 4

Brophy v. *New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986) 7, 8, 9

City of Cleburne v. *Cleburne Living Center*, 473 U.S. 432 (1985) 4

Clark v. *Jeter*, 486 U.S. 45 (1988) 4

Commissioner of Correction v. *Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979) 7

Cruzan v. *Director, Missouri Dep't of Health*, 497 U.S. 261 (1990) 9

Griswold v. *Connecticut*, 381 U.S. 479 (1965) 26

Lane v. *Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978) 7

Matter of Farrell, 108 N.J. 335, 529 A.2d 404 (N.J. 1987) 23

Matter of Quinlan, 70 N.J. 10, 355 A.2d 647 (1976) 5, 6

Matter of Spring, 380 Mass. 629, 405 N.E.2d 115 (1980) 7

Roe v. *Wade*, 410 U.S. 113 (1973) 25

Superintendent of Belchertown State School v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977) 6

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Page

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J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. Palliative Care (forthcoming 1996) 9, 23

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Katherine M. Foley, *Pain, Physician-Assisted Suicide and Euthanasia*, 4 Pain Forum 163 (1995) 9

New Hampshire Physicians Admit Helping Patients Die, Survey Reveals, Hemlock TimeLines, November-December 1994 12

Richard A. Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds*, Boston Globe, Feb. 28, 1992 12

M.A. Lee, et al., *Legalizing Assisted Suicide — Views of Physicians in Oregon*, 334 N. Eng. J. Med. 315 (1996) 11

S.H. Miles, *Physicians and their Patients' Suicides*, 271 JAMA 1786 (1994) 11

New York Will Not Discipline Doctor for his Role in Suicide, N.Y. Times, August 17, 1991 ..... 13, 15

Page

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In the
Supreme Court of the United States

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Nos. 95-1858 and 96-110

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INTEREST OF THE AMICI CURIAE

Amici are professors of law who lecture, write, and provide legal counsel in the areas of Constitutional Law, Criminal Law, and the field of Law, Medicine and Bioethics. *Amici* have widely diverse perspectives but are united in the convic-

tion that this Court should affirm the lower courts' decisions on the ground that the current regime of regulation of physician-assisted suicide represents a thoroughly irrational means for attempting to protect patients from abuse. Rather than protecting patients, the current legal regime actually encourages abuse. In addition, the current regime leaves individual physicians and other health care professionals uncertain as to which of their actions may be found illegal and whether they will have their lives destroyed by an exercise of prosecutorial discretion. *Amici* have filed this brief because of their concern that, for the foregoing reasons and the reasons set forth in their brief, the statutory schemes at issue here undermine respect for law, the rule of law, and the democratic process.

SUMMARY OF ARGUMENT

The State regimes overturned by the lower courts were properly found unconstitutional. Broad distinctions between physician-assisted suicide, on the one hand, and "letting patients die," on the other, are no longer rationally employed by the States to protect patients from abuse. Indeed, they are currently employed in a fashion which exacerbates the risk of abuse. Thus, these regimes are no longer rationally related to the purposes which Petitioners claim they were designed to advance.

Because the law has not kept pace with developments in medical technology, state courts have increasingly carved out exceptions to assisted-suicide laws so as to accommodate the needs of health care personnel and their suffering patients. The exceptions have by this time left little of the rule. In addition, increasing numbers of medical personnel regularly exceed the limits of these exceptions to provide covert assistance in suicide to suffering patients. Little attempt, if any, is made to uncover and prosecute these instances of physician-assisted suicide.

This regime exposes patients to greater risk of abuse than

they would be subject to under a regime of legalized and regulated physician-assisted suicide. As the available literature demonstrates unequivocally, physician-assisted suicide takes place irrespective of whether it is legally permissible or not. To the extent that it is kept strictly criminal, the acts are performed "in the closet" — leaving individual health care professionals to make critical decisions without oversight, without regulation, and without the participation of other health care personnel. On the other hand, to the extent that it is permitted to be practiced on the theory that the physician is "just letting a patient die," individual health care professionals are again left without adequate oversight, regulation, and participation from other health care personnel. By maintaining a broad distinction between merely "letting a patient die" and physician-assisted suicide, the State regimes take (and encourage others to take) decisions to engage in the former much less seriously than decisions to engage in the latter.

Should the decisions below be reversed, important interests will suffer. In addition to being placed at increased risk of abuse, patients will be handicapped in finding adequate relief from inhumane and unnecessary burdens in the dying process. Health care professionals will be forced to operate under legal uncertainty — not knowing whether a particular decision amounts to permissible withholding of life support or impermissible assistance in suicide. Finally, a reversal would undermine the overarching interests of the State in preserving respect for law and the rule of law, and its interest in the proper functioning of democratic processes.

ARGUMENT

THE STATE REGIMES OF REGULATION OVERTURNED BY THE LOWER COURTS ARE UNCONSTITUTIONAL BECAUSE THEY HAVE BECOME IRRATIONAL MEANS FOR ADVANCING THE STATE INTERESTS THAT ARE ALLEGED TO JUSTIFY THEM.

The State legislative regimes involved in these cases violate the Fourteenth Amendment to the United States Constitution because they bear no rational relation to the advancement of the State interests that have been put forward in support of these regimes. *See Allegheny Pittsburgh Coal Co.* v. *County Comm'n of Webster County*, W. Va., 488 U.S. 336 (1989); *see also Clark* v. *Jeter*, 486 U.S. 45 (1988); *City of Cleburne* v. *Cleburne Living Center*, 473 U.S. 432 (1985).

The Solicitor General, in the brief he has submitted in No. 96-110, argues that it is the State interest in protecting the many patients who might be abused if physician-assisted suicide were to be legalized that justifies burdening the liberty interests of the few patients who are forced to suffer when that option is denied them. Br. of Solicitor General at 18-19. In No. 95-1858, he argues that the same interest justifies the distinction that the States maintain between "letting nature take its course," on the one hand, and "physician-assisted suicide," on the other. Br. of Solicitor General at 9. Although the Petitioners and the *amici curiae* who have filed briefs on their behalf make this point in a variety of ways, they are essentially in agreement with the Solicitor General that it is the threat of the abuses that might follow legalization that justifies holding the line against physician-assisted suicide.

However, in drawing the line as they do in prohibiting physician-assisted suicide, the States are actually exacerbating the risks of abuse of patients. Rather than bearing a rational relation to the goal of protecting patients from abuse, the State legislative regimes found unconstitutional by the Courts of Appeals for the Second and Ninth Circuits actually expose

patients to a greater risk of abuse than would be faced under a regime that permitted and regulated physician-assisted suicide.

A. *The current regimes no longer make any rational use of the distinction between physician-assisted suicide and refusal of life-prolonging treatment.*

It is no surprise that State court judges deciding the first "right to die" cases felt it necessary to develop a bright line distinction between suicide and refusal of treatment. The law had not kept pace with developments in medical technology that had created situations where continuation of life-prolonging treatment could seem senseless and even cruel from the point of view of the patient, the patient's family, and the medical personnel involved. Criminal laws regarding homicide and assisted suicide did not make exceptions for cases where the patient begged for death.

In an environment of legislative inactivity on the subject, common law courts acted to provide relief in individual cases in a fashion that would not obviously conflict with the then-governing law. In *Matter of Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), for example, the Supreme Court of New Jersey was asked to authorize the removal of a patient from a ventilator so that she could die rather than be forced to continue to exist in a persistent vegetative state. No evidence was introduced that Karen Quinlan would have felt mechanical ventilation to be a particularly intrusive or offensive medical technique. Presumably she would have been willing to be maintained on mechanical ventilation so long as it promised a future in which she would have preferred life over death. But Ms. Quinlan's father thought she would rather be dead than be maintained in a persistent vegetative state. In granting the right to remove her from the ventilator so that she could die, the New Jersey Supreme Court noted the fact that many might see this as an act of assisting suicide. In reply, all the court could muster was one sentence: "We would see,

however, a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death." *Id.* at 43, 355 A.2d at 665.

Similarly, in *Superintendent of Belchertown State School* v. *Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977), the Supreme Judicial Court of Massachusetts felt it necessary to draw a bright line between physician-assisted suicide and termination of life-sustaining treatment on request. Again, the court gave short shrift to the effort to justify this distinction. In an important footnote, the court said:

> The interest in protecting against suicide seems to require little if any discussion. In the case of the competent adult's refusing medical treatment such an act does not necessarily constitute suicide since (1) in refusing treatment the patient may not have the specific intent to die, and (2) even if he did, to the extent that the cause of death was from natural causes the patient did not set the death producing agent in motion with the intent of causing his own death. Furthermore, the underlying State interest in this area lies in the prevention of irrational self-destruction. What we consider here is a competent, rational decision to refuse treatment when death is inevitable and the treatment offers no hope of cure or preservation of life. There is no connection between the conduct here in issue and any State concern to prevent suicide.

Id. at 743, n.11, 370 N.E.2d at 426, n.11 (citations omitted).

The *Saikewicz* case itself involved a cancer patient whose life would have been extended for only a short period by chemotherapy. The treatment did not offer any hope of cure, and, in recognizing Mr. Saikewicz's right to refuse chemotherapy, the court claimed that his death was

"inevitable" in the sense that the treatment was only "life-prolonging" and not "life-saving."

In later cases, however, the Massachusetts courts extended the right to refuse treatment to embrace situations where treatment was clearly to be classified as "life-saving." For example, in *Lane* v. *Candura*, 6 Mass. App. Ct. 377, 376 N.E.2d 1232 (1978), a patient was permitted to refuse amputation of a gangrenous leg despite the fact that the amputation would have extended her life indefinitely. In *Commissioner of Correction* v. *Myers*, 379 Mass. 255, 399 N.E.2d 452 (1979), the Supreme Judicial Court stated in dictum (and later held in *Matter of Spring*, 380 Mass. 629, 405 N.E.2d 115 (1980)) that patients had the right to refuse life-saving kidney dialysis. In *Lane* and *Spring*, the opinions made no effort to explain how the refusals of life-saving treatment differed from suicide. In *Myers*, the court said only that Myers death "from a refusal of medication or dialysis [would not] necessarily constitute suicide. Rather, his death would result from 'natural causes' since he would not have 'set the death producing agent in motion' with the 'specific intent' of causing his own death." 379 Mass. at 262, 399 N.E.2d at 456.

In *Brophy* v. *New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986), the Massachusetts court took the next step and recognized a right to refuse life-maintaining treatment where the "specific intent" of the patient was to cause his own death. There, the Supreme Judicial Court recognized the right of Paul Brophy to refuse food and water in order to end his continued existence in a persistent vegetative state. Doctors supplied food and water to Mr. Brophy by way of a gastrostomy tube inserted through the wall of his stomach. As with Karen Quinlan, there was no evidence that Paul Brophy would have objected to this as a particularly intrusive or offensive medical technique. Like Ms. Quinlan, he would likely have been willing to be maintained in this fashion if it had offered him a future in which he would have preferred life over death. But the evidence showed conclusively that Mr. Brophy would rather die than persist in a

vegetative state. He had frequently, clearly, and vehemently stated his objections to being kept going in a state like Karen Quinlan's. "If I'm ever like that," he once told his brother, "just shoot me, pull the plug." *Id.* at 428 n. 22, 497 N.E.2d 632 n. 22. Upon admission to the hospital, he had stated to one of his daughters, "If I can't sit up to kiss one of my beautiful daughters, I may as well be six feet under." *Id.* As a result, the court granted him the right to die by dehydration and starvation.

Three dissenters in the *Brophy* case highlighted the tension that existed between the court's holding and laws prohibiting assistance in suicide. Justice Lynch's observations on the point are representative:

> Here, Brophy is not terminally ill, and death is not imminent, and the judge specifically found that Paul Brophy's decision would be to terminate his life by declining food and water. The judge also found that "Brophy's decision, if he were competent to make it, would be primarily based upon the present quality of life possible for him, and would not be based upon the burdens imposed upon him by receiving food and water through a G tube, which burdens are relatively minimal. . . . Where treatment is burdensome and invasive, no such specific intent is normally at issue because, whether or not the patient seeks to die, the patient primarily seeks to end invasive or burdensome treatment. There is no question that the intent here is to end a life that is "over." Moreover, death here would not be from natural causes, i.e., causes he or his agents did not set in motion, but instead, the death producing agent would be set in motion by a volitional act with the intent to cause death.
>
> Suicide is primarily a crime of commission, but can, and indeed must, also be conceived as an act of omission at times. *See In re Caulk*, 125 N.H. 226, 228, 231-232, 480 A.2d 93 (1984) (suicide can be committed by starvation [or dehydration]). If nutrition and hydration are terminated, it is not the illness which causes the death but the decision (and act in accordance therewith) that the illness makes life not worth living. There is no rational distinction between suicide by deprivation of hydration or nutrition in or out of a medical setting — both are suicide.

Id. at 446-47, 497 N.E.2d 642-43 (footnotes omitted).

What has been done in Massachusetts and New Jersey has been done across the country. *See Cruzan* v. *Director, Missouri Dep't of Health*, 497 U.S. 261, 271-77 (1990) (citing, among others, New York and Washington cases). State courts have essentially legalized some forms of physician-assisted suicide in order to adjust the law to the realities of modern medical technology and to provide relief to suffering patients, their families, and their medical personnel. In doing so, the courts and the medical personnel who have followed their decisions have continually developed ingenious ways to grant relief while preserving the appearance of not sanctioning suicide.

Recently, medical personnel have begun to engage in a practice called "terminal sedation." Patients who are not in a persistent vegetative state — who are conscious and competent but suffering from a terminal illness — are offered the option of being sedated to complete unconsciousness and being allowed to die of dehydration, starvation, or some intervening complication. *See* J. Andrew Billings & Susan D. Block, *Slow Euthanasia*, 12 J. Palliative Care (forthcoming 1996); Katherine M. Foley, *Pain, Physician-Assisted Suicide and Euthanasia*, 4 Pain Forum 163 (1995); I. R. Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Palliative Care 25 (1993); N. I. Cherney and R. K. Portenoy, *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. Palliative Care 31 (1994); R.D. Troug, et al., *Barbiturates in the Care of the Terminally*

Ill, 327 N. Eng. J. Med. 1678 (1991).[1] With the advent of such techniques of "refusing treatment" as "terminal sedation," very little seems left to the category of the sort of physician-assisted suicide that is still to be deemed a crime. What does remain seems to serve only as a foil for legitimating everything else that has been allowed. "Physician-assisted suicide," so-called, has become merely a symbol — the thing that every new technique for hastening death claims not to be in order to establish respectability.

Moreover, even those acts that are thought still to constitute prohibited physician-assisted suicide are regularly practiced in the United States. In March 1996, the Journal of the American Medical Association published an article documenting that physicians in the State of Washington commit acts of physician-assisted suicide and euthanasia in percentages that rival those in Holland, where euthanasia and physician-assisted suicide are essentially legalized. *See* Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919 (1996):

> Washington physicians receive requests for physician-assisted suicide or euthanasia almost as frequently as Dutch physicians. Also, physicians in both places grant approximately the same proportion of requests. Our study indicates that in Washington, 24% of patient requests for physician-assisted suicide or euthanasia are ultimately granted; in the Netherlands, less than a third of requests are ultimately granted. Of course, Washington differs from the Netherlands in at least two salient respects, namely, the criminal status of physician-assisted death and the absence of universal health

[1] *See also*, Warren Wolfe, *Three lives, three journeys: Ken/A life, a death, a legacy*, Minneapolis Star Tribune, Feb. 27, 1994, at 14A (describing sixty-two year old, competent nursing home resident who dehydrated and starved himself to death with comfort care provided by nursing home staff).

> coverage. However, these empirical comparisons suggest that patients in both places make these requests regardless of legal constraints on physicians or medical care delivery systems.

Id. at 924 (footnotes omitted).

As regards the extent to which these results are extrapolatable to the United States as a whole, the authors cited surveys conducted in four other states — D. J. Doukas, et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clin. Oncology 1055 (1995); R.S.Shapiro et al., *Willingness to Perform Euthanasia: A Survey of Physician Attitudes*, 154 Arch. Int. Med. 575 (1994); S.H. Miles, *Physicians and their Patients' Suicides*, 271 JAMA 1786 (1994); and M.A. Lee, et al., *Legalizing Assisted Suicide — Views of Physicians in Oregon*, 334 N. Eng. J. Med. 315 (1996) — and conclude that their data "do not suggest that a uniquely favorable degree of support exists for physician-assisted death in Washington." Back, *et al.*, 275 JAMA at 924-25.

In May 1996, the New England Journal of Medicine published an article reporting the results of a poll of 1,600 critical care nurses. The article concluded that a "comparison of the results reported here with those of [the] survey of physicians in Washington State suggests that critical care nurses in the United States may be as willing to be involved in the practice of euthanasia and assisted suicide as are some physicians." David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374, 1377 (1996) (footnotes omitted).

> Of the 1139 nurses who responded (71 percent), 852 said they practiced exclusively in intensive care units for adults in the United States. Of these 852 nurses, 141 (17 percent) reported that they had received requests from patients or family members to perform euthanasia or assist in suicide; 129 (16 percent of those for whom data were available) reported that they had engaged in such

practices; and an additional 35 (4 percent) reported that they had hastened a patient's death by only pretending to provide life-sustaining treatment ordered by a physician. Some nurses reported engaging in these practices without the request or advance knowledge of physicians or others. The method of euthanasia most commonly described was the administration of a high dose of an opiate to a terminally ill patient.

Id. at 1374.

A variety of other sources have reported similar kinds of activity. A survey of the practices of physicians in the San Francisco Bay Area conducted from 1990 to 1995 revealed that 53% of the 1995 respondents "reported having granted an AIDS patient's request at least once for assistance in committing suicide. L. Slome, et al., *Attitudes Toward Assisted Suicide in AIDS: A Five Year Comparison Study*, National Library of Medicine (conference abstract available on World Wide Web at http://sis.nlm.nih/gov/aidsabs.htm) (December 9, 1996). An anonymous survey conducted by the New Hampshire Medical Society in 1994 revealed that "11 of its member physicians admitted giving dying patients lethal injections and another 22 reported granting terminally ill patients' requests for lethal doses of medication so they could commit suicide." *New Hampshire Physicians Admit Helping Patients Die, Survey Reveals*, Hemlock TimeLines, November-December 1994, at 2.

> Of the 597 respondents, 52 percent (310) said if physician-assisted suicide were legal, under certain circumstances, they would prescribe or administer a lethal dose of medication to a terminally ill patient, if requested. Another 19 percent, or 113 physicians, said they would do so even if it were illegal.

Id.; *see also* Richard A. Knox, *1 in 5 Doctors Say They Assisted a Patient's Death, Survey Finds*, *Boston Globe*, Feb. 28, 1992 at 5.

Although it is an "open secret" that such technically illegal practices are taking place, prosecutions and disciplinary actions against the medical personnel involved have thus far been almost non-existent. When the Journal of the American Medical Association reported what was being done by physicians in Washington, prosecutors in that State and officials of the American Medical Association expressed no shock and made no calls for investigative action. When a distinguished New York physician admitted in the pages of the New England Journal of Medicine that he had assisted a cancer patient to commit suicide by means of an overdose of barbiturates, the New York State Board for Professional Medical Conduct found that "no charge of misconduct was warranted." *New York Will Not Discipline Doctor for his Role in Suicide*, N.Y. Times, August 17, 1991 at L-25. The physician had stated quite clearly in print that his intention had been to give his patient a prescription that she could use to end her life:

> As a former director of a hospice program, I know how to use pain medicines to keep patients comfortable and lessen suffering. I explained the philosophy of comfort care, which I strongly believe in. Although Diane understood and appreciated this, she had known of people lingering in what was called relative comfort, and she wanted no part of it. When the time came, she wanted to take her life in the least painful way possible.
>
> • • •
>
> A week later, she phoned me with a request for barbiturates for sleep. Since I knew that this was an essential ingredient in a Hemlock Society suicide, I asked her to come to the office to talk things over. She was more than willing to protect me by participating in a superficial conversation about her insomnia, but it was important to me to know how she planned to use the drugs and to be sure that she was not in despair or overwhelmed in a way that might color her judgment. In our discussion,

it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before ending her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring — spiritual, legal, professional, and personal. Yet I also felt strongly that I was setting her free to get the most out of the time that she had left, and to maintain dignity and control on her own terms until her death.

***

Although the hospice workers, family members, and I tried our best to minimize the suffering and promote comfort, it was clear that the end was approaching. Diane's immediate future held what she feared the most — increasing discomfort, dependence, and hard choices between pain and sedation. She called up her closest friends and asked them to come over to say goodbye, telling them that she would be leaving soon. As we had agreed, she let me know as well. When we met, it was clear that she knew what she was doing, that she was sad and frightened to be leaving, but that she would be even more terrified to stay and suffer. In our tearful goodbye, she promised a reunion in the future at her favorite spot on the edge of Lake Geneva, with dragons swimming in the sunset.

Two days later her husband called to say that Diane had died. She had said her final goodbyes to her husband and son that morning, and asked them to leave her alone

for an hour. After an hour, which must have seemed an eternity, they found her on the couch, lying very still and covered by her favorite shawl. There was no sign of struggle. She seemed to be at peace.

Timothy Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991). Despite Dr. Quill's clear statement of his intentions and his close involvement in the matter, the New York Board based its decision to drop disciplinary action against him on the ground that "[a]s a treating and prescribing physician, he could not know with certainty what use a patient might make of the drugs he has prescribed. Nor is it within any physician's power or authority to compel a patient to do one thing or another with any prescription. Ultimately, these are decisions left to the patients." *New York Will Not Discipline Doctor for his Role in Suicide*, N.Y. Times at L-25.

In the view of at least one prominent legal-medical commentator, the only thing disturbing about the Quill case was that Dr. Quill felt the need to be so open and honest about his true intentions. In criticizing Oregon's initiative provision legalizing physician-assisted suicide, George Annas has argued:

[N]o changes in current law are needed to legalize the prescription of lethal drugs that have a legitimate medical use to terminally ill patients. Although the clear purpose of Ballot Measure 16 is to encourage this prescription practice, the act of putting this proposal into legislative language may itself create the erroneous impression that current legitimate prescription practices are illegal and should be discontinued.

Ballot Measure 16 may also decrease the number of physicians who are willing to prescribe potentially lethal drugs because the patient must make a request for lethal medication not because he or she will feel more secure if it is available and therefore be able to live better, but only "for the purpose of ending his or her life." Likewise, the physician's purpose

in writing the prescription must be to end the patient's life. In short, under Ballot Measure 16, the physician must agree with an explicit plan of suicide by the patient and must participate in the suicide directly and unambiguously.

George Annas, *Death by Prescription: The Oregon Initiative*, 331 New Eng. J. Med. 1240, 1242 (1994).

In the same way that the physician who gives morphine to hasten the death of a suffering patient may protect himself from a charge of euthanasia by claiming that the morphine was given only to suppress pain, the physician who assists in the suicide of a suffering patient is to be able to protect himself by claiming that he intended only to make the patient "feel more secure." Whether the physician has violated the law by assisting suicide depends upon whether others can prove that he intended to do so. The physician is thus encouraged not to discuss the case with others — even other health care professionals on the treatment team — lest she reveal her true intent.

B. *By seeking to maintain a broad legal distinction between physician-assisted suicide and refusal of life-prolonging treatment, the current regimes have placed patients at a heightened risk of abuse.*

1. *The current regimes, which encourage the widespread, covert practice of physician-assisted suicide, leave that practice totally without oversight and regulation.*

Keeping physician-assisted suicide criminal in theory while winking at it in practice creates an environment rife with opportunities for abuse of patients. Petitioners and the *amici curiae* supporting their position claim that they fear the legalization of physician-assisted suicide because there is no guarantee that it will be practiced only in an environment where patients request it competently, voluntarily, insistently,

on the basis of full information, and as a last resort. What is it about allowing it to be practiced in secret that provides the guarantees that would be lacking if it were practiced in the open? If the answer is "nothing," then we are running all the risks of abuse that petitioners fear and denying ourselves the opportunity to know what is going on and to take corrective action as it becomes necessary. By not knowing, we allow to go unchecked the very abuses Petitioners believe to be intrinsic to the practice of physician-assisted suicide. And we discourage even the open communication among practitioners and their patients that is necessary for good medical practice. The authors of the article regarding the practice of physician-assisted suicide in Washington State observed:

> Physicians are often reluctant to discuss these patients with colleagues. Five of the interviewed physicians had not previously discussed their experience with any colleague because of concern for confidentiality or discomfort with the subject. One physician had discussed the experience only after the patient had died; this physician referred the patient to a psychiatrist but did not explicitly mention the reason for the referral and noted, "You don't want everyone aware of it." One physician sought the advice of an ethics committee at the time the request occurred but found the discussion to be so constrained by legal considerations that it was not helpful.

Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA at 923. Fear of legal repercussions may also lead to inadequate discussion with other medical personnel and, most disturbingly, inadequate discussion with the patients themselves. As the author of the article reporting the practices of American critical care nurses reported:

> Not all reported instances of euthanasia or assisted suicide were in response to requests or performed with the

knowledge of patients, family members, or surrogates. . . . Although [the] design [of the author's study] precludes a precise assessment of the number of nurses who reported engaging in euthanasia or assisted suicide without a request from either the patient or a surrogate, it could be calculated that at least 58 nurses (7 percent) had done so at least once. Some of these instances may have occurred with the advance knowledge of patients or surrogates and so may be cases of tacit consent. For example, one nurse described her participation in the following way:

> Usually the patient has either verbalized or written several requests to have his/her suffering ended. It's like we never planned it, but having developed a relationship with the patient, we both knew when it was time. In some instances, the patient was unconscious, on an opiate drip, which I increased or failed to decrease when vital signs dropped. The only physician I've ever had an agreement with is an oncologist I work with, but it's mostly unspoken.

By a similar calculation, 62 nurses (8 percent) reported at least one instance of engaging in euthanasia or assisted suicide without a request from the attending physician.

David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. at 1376. The author concludes:

> An argument often made against physicians' performing euthanasia is that patients may come to fear physicians or distrust their motivations. I do not believe the results of this study suggest that patients or the public should fear or distrust critical care nurses. On the contrary, I think a central finding of this study is that these nurses struggle to uphold important personal values under extremely challenging circumstances — often with little support from physicians. National opinion surveys reveal

> that the majority of the public support policies that would allow euthanasia under certain circumstances. The results of this study should prompt nurses, physicians, and other health care professionals to examine their practices more openly and collaboratively, with the aim of understanding and reducing disagreement over goals and plans.
>
> • • •
>
> Some may take the results presented here as a reason to permit euthanasia in specific circumstances — not just because the demand seems sufficient to result in the practice in any case, but also because by making procedures explicit, one can provide the oversight essential for protecting both patients and health care professionals.

Id. at 1378.

2. ***The current regimes, which take decisions to "let patients die" less seriously than decisions to assist suicide, leave the former decisions without adequate oversight and regulation.***

Great risk of abuse is generated as well by the stubborn maintenance of what has become the dangerous distinction between, on the one hand, committing "physician-assisted suicide," and, on the other hand, merely "letting nature take its course." Such a distinction might make sense in those cases where a patient refuses life-saving or life-prolonging treatment on the ground that the treatment itself is offensive or that the treatment would unduly detract from the quality of the time remaining in the patient's life. The terminally-ill patient who refuses treatment for his cancer so that he can enjoy his remaining days without the debilitating side effects of chemotherapy is not choosing to refuse treatment in order to cut short a life that he has come to hate. In such a case it is meaningful to say that a cooperating physician is not assisting a suicide. But when a patient is praying for death to come as swiftly as possible and, in order to bring it on,

accepts the opportunity to refuse anything that is necessary to keep him alive (food, water, antibiotics, mechanical ventilation, etc.), it is dangerous to pretend that the doctor who turns off the ventilator is not committing an act as serious (morally and legally) as the act of prescribing a lethal dose of pills. Were it not for the physician's decision, the patient would be alive. To maintain that turning off the ventilator is less serious than prescribing the pills encourages physicians to turn off ventilators under circumstances where they would not cause death if they were taking full moral responsibility for their action. *See* Mildred Z. Solomon, et al., *Decisions Near the End of Life: Professional Views on Life-Sustaining Treatments*, 83 Am. J. Pub. Health 14 (1993) (physicians take decision to turn off ventilator less seriously than decision to assist suicide and take decision to deny placement on ventilator less seriously than decision to turn off ventilator).

Petitioners and the *amici curiae* who support their position clearly take less seriously the decision to remove the ventilator-dependent patient from the ventilator than they do the decision to prescribe the pills. The decision to remove a patient from life support so that she may die is at least as subject to abuse as the decision to prescribe a lethal dose of pills. Yet Petitioners and the *amici curiae* who support their position do not contend that the former decisions require any of the safeguards which they claim must be in place before we legalize the latter. As a result, they put at risk of the abuses they believe are inevitable in the practice of physician-assisted suicide the vast numbers of patients who are removed from life support so that they may die.

Petitioners and their supporting *amici curiae* allege that physician-assisted suicide could lead to the following abuses:

- Coercion or undue influence that would make the patient feel forced into opting for physician-assisted suicide.

- Financial incentives that would influence the patient or caregivers to improperly opt for physician-assisted suicide (especially in this era of limited medical resources and managed care).
- Inadequate determinations of mental competence that would lead to permitting mentally-incompetent individuals to opt for physician-assisted suicide.
- Mistaken diagnoses of terminal illness that would lead to mistaken decisions to opt for physician-assisted suicide.
- Inadequate diagnosis and treatment of depression that would lead to improperly-motivated decisions to opt for physician-assisted suicide.
- Inadequate treatment for pain that would lead to unnecessary decisions to opt for physician-assisted suicide.
- Ineffective communication among medical personnel and with patients that would lead to mistaken decisions in favor of physician-assisted suicide.
- Impatience of medical personnel that may lead to too quick a decision in favor of physician-assisted suicide.

Because they do not take the decision to remove a ventilator-dependent patient from a ventilator as seriously as they do the decision to prescribe a lethal dose of drugs, Petitioners and their supporting *amici curiae* fail to recognize that the listed abuses are at least as likely to occur in the former case as in the latter. The patient who asks to be allowed to die by removal from a ventilator is at least as likely as the patient who requests a prescription for lethal drugs to be making the request because of undue influence, financial pressure, clinical depression, or inadequately treated pain. She is at least as likely to be making the decision with questionable mental competence, on the basis of a mistaken diagnosis or

prognosis, because of ineffective communication with or among medical personnel, or as a result of the impatience of medical personnel with her case. Indeed, one would think that the most likely way for medical personnel to act out impatience with a patient's case or concern regarding mounting costs of medical care would be to recommend that life-sustaining treatment just be stopped. There would be no need to recommend assisted suicide.

Likewise, the risks of an error of diagnosis or prognosis are more severe with removal from life-sustaining treatment than they are with the prescription of the lethal dose of drugs. The patient for whom the drugs are prescribed is likely never to use them if the diagnosis or prognosis turns out to be erroneous.[2] The patient who opts for terminal sedation will dehydrate to death in seven days time, whether or not the diagnosis or prognosis was accurate.

Moreover, the fact that all decision-makers are encouraged at each stage to treat decisions to "let nature take its course" less seriously than they would treat a decision to prescribe a lethal dose of medication makes the likelihood of occurrence of the various types of abuse greater in the former case than in the latter.

Maintaining the forced distinction between physician-assisted suicide, on the one hand, and termination of treatment, on the other, exacerbates the risk of abuse of patients in many ways. The fact that the boundary between the two types of acts, although theoretically strict and fraught with dire significance, is almost impossible to fix with certainty in practice is one of the causes of inadequate communication among medical personnel and patients. All parties fear that their statements may later implicate them in an act of assisting suicide. This is also a major cause of inadequate treatment for pain. The physician who uses morphine for pain must

[2] *See* Anthony L. Back, et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996) (noting that 39 percent of terminally ill patients who had asked for and received a lethal prescription never made use of it).

worry, among other things, that someone may later suggest that it was used not just to suppress pain, but also to shorten the life of the patient — thus subjecting her to possible prosecution for assisting suicide. *See* Miles J. Edwards & Susan W. Tolle, *Disconnecting a Ventilator at the Request of a Patient Who Knows He Will Then Die: The Doctor's Anguish*, 117 Annals of Internal Med. 254 (1992).

The unavailability of physician-assisted suicide may also lead patients to feel pressured to end their lives prematurely by refusing life-sustaining treatment. The AIDS patient who is denied the pills that he could keep at his bedside for the day when he has finally reached the end of his endurance may feel obliged to choose to die much earlier through refusing antibiotics for pneumonia at the time when chance has offered him the opportunity to do so. After all, he cannot be sure when again he will have the opportunity.

But, most fundamentally, maintenance of the distinction between physician-assisted suicide and "letting nature take its course" has exacerbated the risk of abuse by providing the conceptual foundation for a regime in which Petitioners permit patients to die by inaction with none of the protections Petitioners would require for a regime in which physician-assisted suicide were legalized.[3] *See*, for example, J. Andrew Billings and Susan D. Block, *Slow Euthanasia*, 12 J. Palliative Care (forthcoming 1996), in which the authors observe as to terminal sedation:

> The slowness of the process — the series of small steps that gradually leads to death — softens the sense of the

[3] One of the very few examples of an effort to protect conscious patients who refuse life-prolonging treatment from potential abuse is *Matter of Farrell*, 108 N.J. 335, 529 A.2d 404 (N.J. 1987). Even there, the protections fell woefully short of those Petitioners would require for legalization of physician-assisted suicide. The Supreme Court of New Jersey required only that "two non-attending physicians examine the patient to confirm that he or she is competent and is fully informed about his or her prognosis, the medical alternatives available, the risks involved, and the likely outcome if medical treatment is disconnected." *Id.* at 415.

physician's agency in this instance of mercy killing. The doctor and nurse may not even be nearby when the death occurs. Moreover, many physicians may have written orders on the patient and many nurses may have been involved in the care, thus diffusing responsibility.

A major concern with this form of slow euthanasia, as with many other instances of end-of-life decision making, is that issues of informed consent rarely surface: the patient is not routinely asked whether he or she desires to end life now. Death is brought on smoothly under the beneficent guidance of the medical staff. The practice is carried out openly, but decisions are usually made privately by the primary physician without outside consultation or review. The procedural safeguards that have been proposed for physician-assisted death are not regularly instituted.

Therefore, some instances of slow euthanasia by the morphine drip may be viewed as involuntary euthanasia. Life-terminating acts without explicit requests from dying patients have also been documented in the Netherlands. The existence of such practices supports concerns that we are moving down a slippery slope toward ending life without the patient's fully informed consent.

In summary, slow euthanasia by the morphine drip as described above is a common, long-standing clinical practice at the end of life, but it is not clearly acknowledged as euthanasia. Its widespread acceptance reflects a belief by physicians that this form of euthanasia is an appropriate, humane response to terminal suffering in the last few days of life. Indeed, slow euthanasia may be a way for the physician to do what seems right for the dying in the absence of clear guidelines and supportive legislation for hastening death, perhaps analogous to the use of "slow codes" prior to the legalization of "no codes" and the assertion of patient rights to participate in decisions about cardiopulmonary resuscitation. However, since slow euthanasia is not fully recognized as

euthanasia, it is not subject to appropriate oversight, including review by experts in symptom management and psychosocial care who can assure that appropriate comfort measures have been considered. Moreover, insofar as fully informed consent may not be obtained from the patient, this practice raises the specter of involuntary euthanasia.

Id.

C. *Important interests, including respect for law and the rule of law, will suffer if this Court permits reinstatement of the irrational legislative regimes at issue here.*

Continued operation of the irrational State legislative regimes involved in these cases comes at great cost to important interests of individual citizens and to important interests of the States themselves.

First, there are the interests of patients, family members, and medical personnel who are forced to endure prolonged, unwanted, senseless, and cruel processes of dying for lack of the option of legalized physician-assisted suicide.

Second, are the interests of the vast number of patients who are put at risk of abuse created by a regime which does not take decisions to cause death by termination of care as seriously as it takes decisions to cause death by physician-assisted suicide.

Third, are the interests of the patients who are put at risk of abuse by a regime which permits illegal physician-assisted suicide to be widely practiced in secret without oversight or regulation.

Fourth, are the interests of those patients who are discriminated against by a regime which makes physician-assisted suicide available only to those who are well-enough connected to find a physician willing to provide such assistance despite the fact that it is illegal. In this respect, the situation is analogous to that which was eliminated by this Court in *Roe* v. *Wade*, 410 U.S. 113 (1973).

Fifth, are the interests of those physicians and other health care professionals who are made to feel insecure in the practice of medicine because of uncertainty as to which actions are in fact illegal and which are not. These individuals face the risk that their professional and personal lives may at anytime be destroyed by an unpredictable exercise of prosecutorial discretion.

Sixth, is the interest of the State in preserving respect for law and the rule of law. To the extent that the State appears to permit physicians to engage in illegal activity with impunity, it sends a message to society that citizens may pick and choose the laws that they must follow. At the very least, it tells physicians and the public as a whole that physicians are above the law. It establishes government by professional aristocracy rather than government by law.

Seventh, is the State's interest in the proper functioning of democratic processes. To the extent that the State permits wholesale violation of an unpopular law, it undercuts citizen incentives for repeal of the law. In this respect, the State legislative regimes involved in these cases are analogous to the Connecticut anti-contraception laws that were struck down in *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).

Conclusion

For the reasons stated above, the decisions of the United States Courts of Appeal for the Second and Ninth Circuits should be affirmed.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, *et al.*,

Petitioners,

v.

HAROLD GLUCKSBERG, *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

DENNIS C. VACCO, ATTORNEY GENERAL OF NEW YORK, *et al.*,

Petitioners,

v.

TIMOTHY E. QUILL, *et al.*,

Respondents.

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BRIEF FOR RONALD DWORKIN, THOMAS NAGEL, ROBERT NOZICK, JOHN RAWLS, THOMAS SCANLON, AND JUDITH JARVIS THOMSON AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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26 pp

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES . . . . . (ii)

INTEREST OF THE AMICI CURIAE 2

INTRODUCTION AND SUMMARY OF ARGUMENT . . . 3

ARGUMENT 5

I. THE LIBERTY INTEREST ASSERTED HERE IS PROTECTED BY THE DUE PROCESS CLAUSE . . 5

II. THIS COURT'S DECISIONS IN *CASEY* AND *CRUZAN* COMPEL RECOGNITION OF A LIBERTY INTEREST HERE 8

A. *Casey* Supports the Liberty Interest Asserted Here 8

B. *Cruzan* Supports the Liberty Interest Asserted Here 9

III. STATE INTERESTS DO NOT JUSTIFY A CATEGORICAL PROHIBITION ON ALL ASSISTED SUICIDE 12

CONCLUSION 20

TABLE OF AUTHORITIES

Cases: Page

Cleveland Bd. of Educ. v. *LeFleur*, 414 U.S. 632 (1974) 6
Cohen v. *California*, 403 U.S. 15 (1971) 5
Cruzan v. *Missouri*, 497 U.S. 261 (1990) . . . . . *passim*
DiGrella v. *Elston*, 858 S.W.2d 698 (Ky. 1993) 15
In re Doe, 411 Mass. 512, 583 N.E.2d 1263 15
Eisenstadt v. *Baird*, 405 U.S. 438 (1973) 6
In re Farrell, 108 N.J. 335, 529 A.2d 404 (1987) 14
Girouard v. *United States*, 328 U.S. 61 (1946) 6
Jacobson v. *Massachusetts*, 197 U.S. 11 (1905) 10
Korematsu v. *United States*, 323 U.S. 214 (1944) 17
Loving v. *Virginia*, 388 U.S. 1 (1967) 6
Mack v. *Mack*, 329 Md. 188, 618 A.2d 744 (1993) 15
In re Martin 450 Mich. 204, 538 N.W.2d 399 (1995) 15
McKay v. *Bergstedt*, 106 Nev. 808, 801 P.2d 617 (1970) . . 13
Palko v. *Connecticut*, 302 U.S. 319 (1937) 5
Planned Parenthood v. *Casey*, 505 U.S. 833 (1992) . . *passim*
Schmerber v. *California*, 384 U.S. 757 (1966) 10
Skinner v. *Oklahoma*, 316 U.S. 535 (1942) 6
In re Tavel, 661 A.2d 1061 (Del. 1995) 15
West Virginia State Bd. of Educ. v. *Barnette*, 319 U.S. 624 (1943) 6

Statutory Provisions:

Cal. Penal Code § 401 (1992) 15
Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800-.827 (1995) 16

Scholarly Authorities:

Charles H. Baron, *et. al.*, *A Model State Act to Authorize and Regulate Physician - Assisted Suicide*, 33 Harv. J. Legis. 1 (1996) 16

TABLE OF AUTHORITIES—Continued

Page

Charles Fried, *Right and Wrong* (1978) 6

Allison C. Hall, *To Die With Dignity: Comparing Physician-Assisted Suicide in the United States, Japan, and the Netherlands*, 74 Wash. U. L. Q. 803 (1996) 15

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INTEREST OF THE AMICI CURIAE

Amici are six moral and political philosophers who differ on many issues of public morality and policy. They are united, however, in their conviction that respect for fundamental principles of liberty and justice, as well as for the American constitutional tradition, requires that the decisions of the Courts of Appeals be affirmed.[1]

[1] This brief is filed on the consent of all parties. *See* S. Ct. R. 37.3(a). It is not filed on behalf of any corporation. *See* S. Ct. R. 29.1.

INTRODUCTION AND SUMMARY OF ARGUMENT

These cases do not invite or require the Court to make moral, ethical or religious judgments about how people should approach or confront their death or about when it is ethically appropriate to hasten one's own death or to ask others for help in doing so. On the contrary, they ask the Court to recognize that individuals have a constitutionally protected interest in making those grave judgments for themselves, free from the imposition of any religious or philosophical orthodoxy by court or legislature. States have a constitutionally legitimate interest in protecting individuals from irrational, ill-informed, pressured or unstable decisions to hasten their own death. To that end, states may regulate and limit the assistance that doctors may give individuals who express a wish to die. But states may not deny people in the position of the patient-plaintiffs in these cases the opportunity to demonstrate, through whatever reasonable procedures the state might institute—even procedures that err on the side of caution—that their decision to die is indeed informed, stable, and fully free. Denying that opportunity to terminally-ill patients who are in agonizing pain or otherwise doomed to an existence they regard as intolerable could only be justified on the basis of a religious or ethical conviction about the value or meaning of life itself. Our Constitution forbids government to impose such convictions on its citizens.

Petitioners and the amici who support them offer two contradictory arguments. Some deny that the patient-plaintiffs have any constitutionally protected liberty interest in hastening their own deaths.[2] But that liberty interest flows directly from this Court's previous decisions. It flows

[2] *See, e.g.*, Brief for the Petitioners at 25-33, *Washington* v. *Glucksberg*; Brief for Petitioners Vacco and Pataki at 19-20, *Vacco* v. *Quill*; Brief Amici Curiae of the United States Catholic Conference, New York Catholic Conference, et al. in Support of Petitioners at 7-21, *Washington* v. *Glucksberg*; Brief for the Institute for Public Affairs of the Union of Orthodox Jewish Congregations of America and the Rabbinical Council of America as Amici Curiae in Support of Petitioners at 5-13, *Vacco* v. *Quill* and *Washington* v. *Glucksberg*.

from the right of people to make their own decisions about matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992).

The Solicitor General, urging reversal in support of Petitioners, recognizes that the patient-plaintiffs do have a constitutional liberty interest at stake in these cases. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 12, *Washington* v. *Vacco* [hereinafter Brief for the United States] ("The term 'liberty' in the Due Process Clause . . . is broad enough to encompass an interest on the part of terminally ill, mentally competent adults in obtaining relief from the kind of suffering experienced by the plaintiffs in this case, which includes not only severe physical pain, but also the despair and distress that comes from physical deterioration and the inability to control basic bodily functions."); *see also id.* at 13 ("*Cruzan* . . . supports the conclusion that a liberty interest is at stake in this case."). The Solicitor General nevertheless argues that Washington and New York properly ignored this profound interest when they required the patient-plaintiffs to live on in circumstances they found intolerable. He argues that a state may simply declare that it is unable to devise a regulatory scheme that would adequately protect patients whose desire to die might be ill-informed or unstable or foolish or not fully free, and that a state may therefore fall back on a blanket prohibition. This Court has never accepted that patently dangerous rationale for denying protection altogether to a conceded fundamental constitutional interest. It would be a serious mistake to do so now. If that rationale were accepted, an interest acknowledged to be constitutionally protected would be rendered empty.

ARGUMENT

I. THE LIBERTY INTEREST ASSERTED HERE IS PROTECTED BY THE DUE PROCESS CLAUSE

The Due Process Clause of the Fourteenth Amendment protects the liberty interest asserted by the patient-plaintiffs here.

Certain decisions are momentous in their impact on the character of a person's life—decisions about religious faith, political and moral allegiance, marriage, procreation and death, for example. Such deeply personal decisions reflect controversial questions about how and why human life has value. In a free society, individuals must be allowed to make those decisions for themselves, out of their own faith, conscience and convictions. This Court has insisted, in a variety of contexts and circumstances, that this great freedom is among those protected by the Due Process Clause as essential to a community of "ordered liberty." *Palko* v. *Connecticut*, 302 U.S. 319, 325 (1937). In its recent decision in *Planned Parenthood* v. *Casey*, 505 U.S. 833, 851 (1992), the Court offered a paradigmatic statement of that principle:

> matters[] involving the most intimate and personal choices a person may make in a lifetime, choices central to a person's dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment.

That declaration reflects an idea underlying many of our basic constitutional protections.[3] As the Court explained in

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[3] In *Cohen* v. *California*, 403 U.S. 15, 24 (1971), for example, this Court held that the First Amendment guarantee of free speech and expression derives from "the belief that no other approach would comport with the premise of individual dignity and choice upon which our political system rests." Interpreting the religion clauses of the First Amendment, this Court has explained that "[t]he victory for freedom of thought recorded in our Bill of Rights recognizes that in the domain of conscience

West Virginia State Board of Education v. *Barnette*, 319 U.S. 624, 642 (1943):

> If there is any fixed star in our constitutional constellation, it is that no official . . . can prescribe what shall be orthodox in politics, nationalism, religion, or other matters of opinion or force citizens to confess by word or act their faith therein.

A person's interest in following his own convictions at the end of life is so central a part of the more general right to

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there is a moral power higher than the State." *Girouard* v. *United States*, 328 U.S. 61, 68 (1946). And, in a number of Due Process cases, this Court has protected this conception of autonomy by carving out a sphere of personal family life that is immune from government intrusion. *See, e.g., Cleveland Bd. of Educ.* v. *LeFleur*, 414 U.S. 632, 639 (1974) ("This Court has long recognized that freedom of personal choice in matters of marriage and family life is one of the liberties protected by the Due Process Clause of the Fourteenth Amendment."); *Eisenstadt* v. *Baird*, 405 U.S. 438, 453 (1973) (recognizing right "to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision to bear and beget a child"); *Skinner* v. *Oklahoma*, 316 U.S. 535, 541 (1942) (holding unconstitutional a state statute requiring the sterilization of individuals convicted of three offenses, in large part because the state's actions unwarrantedly intruded on marriage and procreation, "one of the basic civil rights of man"); *Loving* v. *Virginia*, 388 U.S. 1, 12 (1967) (striking down the criminal prohibition of interracial marriages as an infringement of the right to marry and holding that "[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness by free men").

These decisions recognize as constitutionally immune from state intrusion that realm in which individuals make "intimate and personal" decisions that define the very character of their lives. *See* Charles Fried, *Right and Wrong* 146–47 (1978) ("What a person is, what he wants, the determination of his life plan, of his concept of the good, are the most intimate expressions of self-determination, and by asserting a person's responsibility for the results of this self-determination, we give substance to the concept of liberty.").

make "intimate and personal choices" for himself that a failure to protect that particular interest would undermine the general right altogether. Death is, for each of us, among the most significant events of life. As the Chief Justice said in *Cruzan* v. *Missouri*, 497 U.S. 261, 281 (1990), "[t]he choice between life and death is a deeply personal decision of obvious and overwhelming finality." Most of us see death—whatever we think will follow it—as the final act of life's drama, and we want that last act to reflect our own convictions, those we have tried to live by, not the convictions of others forced on us in our most vulnerable moment.

Different people, of different religious and ethical beliefs, embrace very different convictions about which way of dying confirms and which contradicts the value of their lives. Some fight against death with every weapon their doctors can devise. Others will do nothing to hasten death even if they pray it will come soon. Still others, including the patient-plaintiffs in these cases, want to end their lives when they think that living on, in the only way they can, would disfigure rather than enhance the lives they had created. Some people make the latter choice not just to escape pain. Even if it were possible to eliminate all pain for a dying patient—and frequently that is not possible—that would not end or even much alleviate the anguish some would feel at remaining alive, but intubated, helpless and often sedated near oblivion.

None of these dramatically different attitudes about the meaning of death can be dismissed as irrational. None should be imposed, either by the pressure of doctors or relatives or by the fiat of government, on people who reject it. Just as it would be intolerable for government to dictate that doctors never be permitted to try to keep someone alive as long as possible, when that is what the patient wishes, so it is intolerable for government to dictate that doctors may never, under any circumstances, help someone to die who believes that further life means only degradation. The Constitution insists that people must be free to make these deeply personal decisions for themselves and must not be forced to end their lives in a way that appalls them, just because that is what some majority thinks proper.

II. THIS COURT'S DECISIONS IN *CASEY* AND *CRUZAN* COMPEL RECOGNITION OF A LIBERTY INTEREST HERE

A. *Casey* Supports the Liberty Interest Asserted Here

In *Casey*, this Court, in holding that a State cannot constitutionally proscribe abortion in all cases, reiterated that the Constitution protects a sphere of autonomy in which individuals must be permitted to make certain decisions for themselves. The Court began its analysis by pointing out that "[a]t the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." 505 U.S. at 851. Choices flowing out of these conceptions, on matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." *Id.* "Beliefs about these matters," the Court continued, "could not define the attributes of personhood were they formed under compulsion of the State." *Id.*

In language pertinent to the liberty interest asserted here, the Court explained why decisions about abortion fall within this category of "personal and intimate" decisions. A decision whether or not to have an abortion, "originat[ing] within the zone of conscience and belief," involves conduct in which "the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law." *Id.* at 852. As such, the decision necessarily involves the very "destiny of the woman" and is inevitably "shaped to a large extent on her own conception of her spiritual imperatives and her place in society." *Id.* Precisely because of these characteristics of the decision, "the State is [not] entitled to proscribe [abortion] in all instances." *Id.* Rather, to allow a total prohibition on abortion would be to permit a state to impose one conception of the meaning and value of human existence on all individuals. This the Constitution forbids.

The Solicitor General nevertheless argues that the right to abortion could be supported on grounds other than this

autonomy principle, grounds that would not apply here. He argues, for example, that the abortion right might flow from the great burden an unwanted child imposes on its mother's life. Brief for the United States at 14–15. But whether or not abortion rights could be defended on such grounds, they were not the grounds on which this Court in fact relied. To the contrary, the Court explained at length that the right flows from the constitutional protection accorded all individuals to "define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S. at 851.

The analysis in *Casey* compels the conclusion that the patient-plaintiffs have a liberty interest in this case that a state cannot burden with a blanket prohibition. Like a woman's decision whether to have an abortion, a decision to die involves one's very "destiny" and inevitably will be "shaped to a large extent on [one's] own conception of [one's] spiritual imperatives and [one's] place in society." *Id.* at 852. Just as a blanket prohibition on abortion would involve the improper imposition of one conception of the meaning and value of human existence on all individuals, so too would a blanket prohibition on assisted suicide. The liberty interest asserted here cannot be rejected without undermining the rationale of *Casey*. Indeed, the lower court opinions in the Washington case expressly recognized the parallel between the liberty interest in *Casey* and the interest asserted here. *See Compassion in Dying* v. *Washington*, 79 F.3d 790, 801 (9th Cir. 1996) (en banc) ("In deciding right-to-die cases, we are guided by the Court's approach to the abortion cases. *Casey* in particular provides a powerful precedent, for in that case the Court had the opportunity to evaluate its past decisions and to determine whether to adhere to its original judgment."), *aff'g*, 850 F. Supp. 1454, 1459 (W.D. Wash. 1994) ("[T]he reasoning in *Casey* [is] highly instructive and almost prescriptive . . ."). This Court should do the same.

B. *Cruzan* Supports the Liberty Interest Asserted Here

We agree with the Solicitor General that this Court's decision in "*Cruzan* . . . supports the conclusion that a

liberty interest is at stake in this case." Brief for the United States at 8. Petitioners, however, insist that the present cases can be distinguished because the right at issue in *Cruzan* was limited to a right to reject an unwanted invasion of one's body. But this Court repeatedly has held that in appropriate circumstances a state may require individuals to accept unwanted invasions of the body. *See, e.g., Schmerber* v. *California*, 384 U.S. 757 (1966) (extraction of blood sample from individual suspected of driving while intoxicated, notwithstanding defendant's objection, does not violate privilege against self-incrimination or other constitutional rights); *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905) (upholding compulsory vaccination for smallpox as reasonable regulation for protection of public health). The liberty interest at stake in *Cruzan* was a more profound one. If a competent patient has a constitutional right to refuse life-sustaining treatment, then, the Court implied, the state could not override that right. The regulations upheld in *Cruzan* were designed only to ensure that the individual's wishes were ascertained correctly. Thus, if *Cruzan* implies a right of competent patients to refuse life-sustaining treatment, that implication must be understood as resting not simply on a right to refuse bodily invasions but on the more profound right to refuse medical intervention when what is at stake is a momentous personal decision, such as the timing and manner of one's death. In her concurrence, Justice O'Connor expressly recognized that the right at issue involved a "deeply personal decision" that is "inextricably intertwined" with our notion of "self-determination." 497 U.S. at 287-89.

Cruzan also supports the proposition that a state may not burden a terminally ill patient's liberty interest in determining the time and manner of his death by prohibiting doctors from terminating life support. Seeking to distinguish *Cruzan*, Petitioners insist that a state may nevertheless burden that right in a different way by forbidding doctors to assist in the suicide of patients who are not on life-support machinery. They argue that doctors who remove life support are only allowing a natural process to end in death whereas doctors who prescribe lethal drugs are intervening to cause death. So, according to this argument, a state has an independent justification for forbidding doctors to assist in

suicide that it does not have for forbidding them to remove life support. In the former case though not the latter, it is said, the state forbids an act of killing that is morally much more problematic than merely letting a patient die.

This argument is based on a misunderstanding of the pertinent moral principles. It is certainly true that when a patient does not wish to die, different acts, each of which foreseeably results in his death, nevertheless have very different moral status. When several patients need organ transplants and organs are scarce, for example, it is morally permissible for a doctor to deny an organ to one patient, even though he will die without it, in order to give it to another. But it is certainly not permissible for a doctor to kill one patient in order to use his organs to save another. The morally significant difference between those two acts is *not*, however, that killing is a positive act and not providing an organ is a mere omission, or that killing someone is worse than merely allowing a "natural" process to result in death. It would be equally impermissible for a doctor to let an injured patient bleed to death, or to refuse antibiotics to a patient with pneumonia—in each case the doctor would have allowed death to result from a "natural" process—in order to make his organs available for transplant to others. A doctor violates his patient's rights regardless of whether the doctor acts or refrains from acting, against the patient's wishes, in a way that is designed to cause death.

When a competent patient does want to die, the moral situation is obviously different, because then it makes no sense to appeal to the patient's right not to be killed as a reason why an act designed to cause his death is impermissible. From the patient's point of view, there is no morally pertinent difference between a doctor's terminating treatment that keeps him alive, if that is what he wishes, and a doctor's helping him to end his own life by providing lethal pills he may take himself, when ready, if that is what he wishes—except that the latter may be quicker and more humane. Nor is that a pertinent difference from the doctor's point of view. If and when it is permissible for him to act with death in view, it does not matter which of those two means he and his patient choose. If it is permissible for a doctor deliberately to withdraw medical treatment in order to

allow death to result from a natural process, then it is equally permissible for him to help his patient hasten his own death more actively, if that is the patient's express wish.

It is true that some doctors asked to terminate life support are reluctant and do so only in deference to a patient's right to compel them to remove unwanted invasions of his body. But other doctors, who believe that their most fundamental professional duty is to act in the patient's interests and that, in certain circumstances, it is in their patient's best interests to die, participate willingly in such decisions: they terminate life support to cause death because they know that is what their patient wants. *Cruzan* implied that a state may not absolutely prohibit a doctor from deliberately causing death, at the patient's request, in that way and for that reason. If so, then a state may not prohibit doctors from deliberately using more direct and often more humane means to the same end when that is what a patient prefers. The fact that failing to provide life sustaining treatment may be regarded as "only letting nature take its course" is no more morally significant in this context, when the patient wishes to die, than in the other, when he wishes to live. Whether a doctor turns off a respirator in accordance with the patient's request or prescribes pills that a patient may take when he is ready to kill himself, the doctor acts with the same intention: to help the patient die.

The two situations do differ in one important respect. Since patients have a right not to have life support machinery attached to their bodies, they have, in principle, a right to compel its removal. But that is not true in the case of assisted suicide: patients in certain circumstances have a right that the state not forbid doctors to assist in their deaths, but they have no right to compel a doctor to assist them. The right in question, that is, is only a right to the help of a willing doctor.

III. STATE INTERESTS DO NOT JUSTIFY A CATEGORICAL PROHIBITION ON ALL ASSISTED SUICIDE

The Solicitor General concedes that "a competent, terminally ill adult has a constitutionally cognizable liberty

interest in avoiding the kind of suffering experienced by the plaintiffs in this case." Brief for the United States at 8. He agrees that this interest extends not only to avoiding pain, but to avoiding an existence the patient believes to be one of intolerable indignity or incapacity as well. *Id.* at 12. The Solicitor General argues, however, that states nevertheless have the right to "override" this liberty interest altogether, because a state could reasonably conclude that allowing doctors to assist in suicide, even under the most stringent regulations and procedures that could be devised, would unreasonably endanger the lives of a number of patients who might ask for death in circumstances when it is plainly not in their interests to die or when their consent has been improperly obtained.

This argument is unpersuasive, however, for at least three reasons. *First*, in *Cruzan*, this Court noted that its various decisions supported the recognition of a general liberty interest in refusing medical treatment, even when such refusal could result in death. 497 U.S. at 278-79. The various risks described by the Solicitor General apply equally to those situations. For instance, a patient kept alive only by an elaborate and disabling life support system might well become depressed, and doctors might be equally uncertain whether the depression is curable: such a patient might decide for death only because he has been advised that he will die soon anyway or that he will never live free of the burdensome apparatus, and either diagnosis might conceivably be mistaken. Relatives or doctors might subtly or crudely influence that decision, and state provision for the decision may (to the same degree in this case as if it allowed assisted suicide) be thought to encourage it.

Yet there has been no suggestion that states are incapable of addressing such dangers through regulation. In fact, quite the opposite is true. In *McKay* v. *Bergstedt*, 106 Nev. 808, 801 P.2d 617 (1990), for example, the Nevada Supreme Court held that "competent adult patients desiring to refuse or discontinue medical treatment" must be examined by two non-attending physicians to determine whether the patient is mentally competent, understands his prognosis and treatment options, and appears free of coercion or pressure in making his decision. *Id.* at 827-28, 801 P.2d at 630. *See also id.*

(in the case of terminally-ill patients with natural life expectancy of less than six months, patient's right of self-determination shall be deemed to prevail over state interests, whereas non-terminal patient's decision to terminate life-support systems must first be weighed against relevant state interests by trial judge); *In re Farrell*, 108 N.J. 335, 354, 529 A.2d 404, 413 (1987) (terminally-ill patient requesting termination of life-support must be determined to be competent and properly informed about prognosis, available treatment options and risks, and to have made decision voluntarily and without coercion). Those protocols served to guard against precisely the dangers that the Solicitor General raises. The case law contains no suggestion that such protocols are inevitably insufficient to prevent deaths that should have been prevented.

Indeed, the risks of mistake are overall greater in the case of terminating life support. *Cruzan* implied that a state must allow individuals to make such decisions through an advance directive stipulating either that life support be terminated (or not initiated) in described circumstances when the individual was no longer competent to make such a decision himself, or that a designated proxy be allowed to make that decision. All the risks just described are present when the decision is made through or pursuant to such an advance directive, and a grave further risk is added: that the directive, though still in force, no longer represents the wishes of the patient. The patient might have changed his mind before he became incompetent, though he did not change the directive, or his proxy may make a decision that the patient would not have made himself if still competent. In *Cruzan*, this Court held that a state may limit these risks through reasonable regulation. It did not hold—or even suggest—that a state may avoid them through a blanket prohibition that, in effect, the liberty interest altogether.

Second, nothing in the record supports the conclusion that no system of rules and regulations could adequately reduce the risk of mistake. As discussed above, the experience of states in adjudicating requests to have life-sustaining

treatment removed indicates the opposite.[4] The Solicitor General has provided no persuasive reason why the same sort of procedures could not be applied effectively in the case of a competent individual's request for physician-assisted suicide.

Indeed, several very detailed schemes for regulating physician-assisted suicide have been submitted to the voters of some states[5] and one has been enacted.[6] In addition,

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[4] When state protocols are observed, sometimes the patient is permitted to die and sometimes not. *See, e.g., In re Tavel*, 661 A.2d 1061 (Del. 1995) (affirming finding that petitioner–daughter had proven by clear and convincing evidence that incompetent patient would want life support systems removed); *In re Martin*, 450 Mich. 204, 538 N.W.2d 399 (1995) (holding that wife's testimony and affidavit did not constitute clear and convincing evidence of incompetent patient's pre-injury decision to decline life–sustaining medical treatment in patient's present circumstances); *DiGrella* v. *Elston*, 858 S.W.2d 698, 710 (Ky. 1993) ("If the attending physician, the hospital or nursing home ethics committee where the patient resides, and the legal guardian or next of kin all agree and document the patient's wishes and condition, and if no one disputes their decision, no court order is required to proceed to carry out [an incompetent] patient's wishes"); *Mack* v. *Mack*, 329 Md. 188, 618 A.2d 744 (1993) (holding that wife failed to provide clear and convincing evidence that incompetent husband would want life support removed); *In re Doe*, 411 Mass. 512, 583 N.E.2d 1263 (applying doctrine of substituted judgment and holding that evidence supported finding that, if incompetent patient were capable of making a choice, she would remove life support).

[5] For example, 46% of California voters supported Proposition 161, which would have legalized physician-assisted suicide, in November 1992. The measure was a proposed amendment to Cal. Penal Code § 401 (1992) which currently makes assisted suicide a felony. Those who did not vote for the measure cited mainly religious reasons or concerns that the proposed law was flawed because it lacked safeguards against abuse and needed more restrictions that might be easily added, such as a waiting period and a psychological examination. Alison C. Hall, *To Die With Dignity: Comparing Physician-Assisted Suicide in the United States, Japan, and the Netherlands*, 74 Wash. U. L. Q. 803, 817 n.84 (1996).

concerned groups, including a group of distinguished professors of law and other professionals, have drafted and defended such schemes. *See*, *e.g.*, Charles H. Baron, *et. al.*, *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. Legis. 1 (1996). Such draft statutes propose a variety of protections and review procedures designed to insure against mistakes, and neither Washington nor New York attempted to show that such schemes would be porous or ineffective. Nor does the Solicitor General's brief: it relies instead mainly on flat and conclusory statements. It cites a New York Task Force report, written before the proposals just described were drafted, whose findings have been widely disputed and were implicitly rejected in the opinion of the Second Circuit below. *See generally Quill* v. *Vacco*, 80 F.3d 716 (2d Cir. 1996). The weakness of the Solicitor General's argument is signalled by his strong reliance on the experience in the Netherlands which, in effect, allows assisted suicide pursuant to published guidelines. Brief for the United States at 23-24. The Dutch guidelines are more permissive than the proposed and model American statutes, however. The Solicitor General deems the Dutch practice of ending the lives of people like neo-nates who cannot consent particularly

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[6] In November 1994, Oregon voters approved the Oregon Death With Dignity Act through voter initiative, legalizing physician-assisted suicide under limited circumstances. Oregon Death With Dignity Act, Or. Rev. Stat. §§ 127.800-.827 (1995). Under the Oregon Act, a capable adult resident of the state, who

> has been determined by the attending physician and consulting physician to be suffering from a terminal disease, and who has voluntarily expressed his or her wish to die, may make a written request for medication for the purpose of ending his life in a human and dignified manner in accordance with [the provisions of the Act].

Or. Rev. Stat. § 127.805 (1995). The Act provides specific definitions of essential terms such as "incapable" and "terminal disease." The Act also provides numerous other regulations designed to safeguard the integrity of the process.

noteworthy, for example, but that practice could easily and effectively be made illegal by any state regulatory scheme without violating the Constitution.

The Solicitor General's argument would perhaps have more force if the question before the Court were simply whether a state has any rational basis for an absolute prohibition; if that were the question, then it might be enough to call attention to risks a state might well deem not worth running. But, as the Solicitor General concedes, the question here is a very different one: whether a state has interests sufficiently compelling to allow it to take the extraordinary step of altogether refusing the exercise of a liberty interest of constitutional dimension. In those circumstances, the burden is plainly on the state to demonstrate that the risk of mistakes is very high, and that no alternative to complete prohibition would adequately and effectively reduce those risks. Neither of the Petitioners has made such a showing.

Nor could they. The burden of proof on any state attempting to show this would be very high. Consider, for example, the burden a state would have to meet to show that it was entitled altogether to ban public speeches in favor of unpopular causes because it could not guarantee, either by regulations short of an outright ban or by increased police protection, that such speeches would not provoke a riot that would result in serious injury or death to an innocent party. Or that it was entitled to deny those accused of crime the procedural rights that the Constitution guarantees, such as the right to a jury trial, because the security risk those rights would impose on the community would be too great. One can posit extreme circumstances in which some such argument would succeed. *See*, *e.g.*, *Korematsu* v. *United States*, 323 U.S. 214 (1944) (permitting United States to detain individuals of Japanese ancestry during wartime). But these circumstances would be extreme indeed, and the *Korematsu* ruling has been widely and severely critized.

Third, it is doubtful whether the risks the Solicitor General cites are even of the right character to serve as justification for an absolute prohibition on the exercise of an important liberty interest. The risks fall into two groups. The first is

the risk of medical mistake, including a misdiagnosis of competence or terminal illness. To be sure, no scheme of regulation, no matter how rigorous, can altogether guarantee that medical mistakes will not be made. But the Constitution does not allow a state to deny patients a great variety of important choices, for which informed consent is properly deemed necessary, just because the information on which the consent is given may, in spite of the most strenuous efforts to avoid mistake, be wrong. Again, these identical risks are present in decisions to terminate life support, yet they do not justify an absolute prohibition on the exercise of the right.

The second group consists of risks that a patient will be unduly influenced by considerations that the state might deem it not in his best interests to be swayed by, for example, the feelings and views of close family members. Brief for the United States at 20. But what a patient regards as proper grounds for such a decision normally reflects exactly the judgments of personal ethics—of why his life is important and what affects its value—that patients have a crucial liberty interest in deciding for themselves. Even people who are dying have a right to hear and, if they wish, act on what others might wish to tell or suggest or even hint to them, and it would be dangerous to suppose that a state may prevent this on the ground that it knows better than its citizens when they should be moved by or yield to particular advice or suggestion in the exercise of their right to make fateful personal decisions for themselves. It is not a good reply that some people may not decide as they really wish—as they would decide, for example, if free from the "pressure" of others. That possibility could hardly justify the most serious pressure of all—the criminal law which tells them that they may not decide for death if they need the help of a doctor in dying, no matter how firmly they wish it.

There is a fundamental infirmity in the Solicitor General's argument. He asserts that a state may reasonably judge that the risk of "mistake" to some persons justifies a prohibition that not only risks but insures and even aims at what would undoubtedly be a vastly greater number of "mistakes" of the opposite kind—preventing many thousands of competent people who think that it disfigures their lives to continue living, in the only way left to them, from escaping that—to

them—terrible injury. A state grievously and irreversibly harms such people when it prohibits that escape. The Solicitor General's argument may seem plausible to those who do not agree that individuals are harmed by being forced to live on in pain and what they regard as indignity. But many other people plainly do think that such individuals are harmed, and a state may not take one side in that essentially ethical or religious controversy as its justification for denying a crucial liberty.

Of course, a state has important interests that justify regulating physician-assisted suicide. It may be legitimate for a state to deny an opportunity for assisted suicide when it acts in what it reasonably judges to be the best interests of the potential suicide, and when its judgment on that issue does not rest on contested judgments about "matters involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Casey*, 505 U.S. at 851. A state might assert, for example, that people who are not terminally ill, but who have formed a desire to die, are, as a group, very likely later to be grateful if they are prevented from taking their own lives. It might then claim that it is legitimate, out of concern for such people, to deny any of them a doctor's assistance. This Court need not decide now the extent to which such paternalistic interests might override an individual's liberty interest. No one can plausibly claim, however—and it is noteworthy that neither Petitioners nor the Solicitor General does claim—that any such prohibition could serve the interests of any significant number of terminally ill patients. On the contrary, any paternalistic justification for an absolute prohibition of assistance to such patients would of necessity appeal to a widely contested religious or ethical conviction many of them, including the patient-plaintiffs, reject. Allowing *that* justification to prevail would vitiate the liberty interest.

Even in the case of terminally ill patients, a state has a right to take all reasonable measures to insure that a patient requesting such assistance has made an informed, competent, stable and uncoerced decision. It is plainly legitimate for a state to establish procedures through which professional and administrative judgments can be made about these matters,

and to forbid doctors to assist in suicide when its reasonable procedures have not been satisfied. States may be permitted considerable leeway in designing such procedures. They may be permitted, within reason, to err on what they take to be the side of caution. But they may not use the bare possibility of error as justification for refusing to establish any procedures at all and relying instead on a flat prohibition.

CONCLUSION

Each individual has a right to make the "most intimate and personal choices central to personal dignity and autonomy." That right encompasses the right to exercise some control over the time and manner of one's death.

The patient-plaintiffs in these cases were all mentally competent individuals in the final phase of terminal illness and died within months of filing their claims. Jane Doe described how her advanced cancer made even the most basic bodily functions such as swallowing, coughing, and yawning extremely painful and that it was "not possible for [her] to reduce [her] pain to an acceptable level of comfort and to retain an alert state." Faced with such circumstances, she sought to be able to "discuss freely with [her] treating physician [her] intention of hastening [her] death through the consumption of drugs prescribed for that purpose." *Quill* v. *Vacco*, 80 F.2d 716, 720 (2d Cir. 1996) (quoting declaration of Jane Doe). George A. Kingsley, in advanced stages of AIDS which included, among other hardships, the attachment of a tube to an artery in his chest which made even routine functions burdensome and the development of lesions on his brain, sought advice from his doctors regarding prescriptions which could hasten his impending death. *Id.* Jane Roe, suffering from cancer since 1988, had been almost completely bed-ridden since 1993 and experienced constant pain which could not be alleviated by medication. After undergoing counseling for herself and her family, she desired to hasten her death by taking prescription drugs. *Compassion in Dying* v. *Washington*, 850 F. Supp. 1454, 1456 (1994). John Doe, who had experienced numerous AIDS-related ailments since 1991, was "especially cognizant of the suffering imposed by a lingering terminal illness

because he was the primary caregiver for his long-term companion who died of AIDS" and sought prescription drugs from his physician to hasten his own death after entering the terminal phase of AIDS. *Id.* at 1456-57. James Poe suffered from emphysema which caused him "a constant sensation of suffocating" as well as a cardiac condition which caused severe leg pain. Connected to an oxygen tank at all times but unable to calm the panic reaction associated with his feeling of suffocation even with regular doses of morphine, Mr. Poe sought physician-assisted suicide. *Id.* at 1457.

A state may not deny the liberty claimed by the patient-plaintiffs in these cases without providing them an opportunity to demonstrate, in whatever way the state might reasonably think wise and necessary, that the conviction they expressed for an early death is competent, rational, informed, stable and uncoerced.

Affirming the decisions by the Courts of Appeals would establish nothing more than that there is such a constitutionally protected right in principle. It would establish only that some individuals, whose decisions for suicide plainly cannot be dismissed as irrational or foolish or premature, must be accorded a reasonable opportunity to show that their decision for death is informed and free. It is not necessary to decide precisely which patients are entitled to that opportunity. If, on the other hand, this Court reverses the decisions below, its decision could only be justified by the momentous proposition—a proposition flatly in conflict with the spirit and letter of the Court's past decisions—that an American citizen does not, after all, have the right, even in principle, to live and die in the light of his own religious and ethical beliefs, his own convictions about why his life is valuable and where its value lies.

Respectfully submitted,

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No. 95-1858 and No. 96-110

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

—against—

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents,

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, ATTORNEY GENERAL OF WASHINGTON,

Petitioners,

—against—

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, MD. PH.D.,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT AND NINTH CIRCUIT

BRIEF OF *AMICUS CURIAE* BIOETHICISTS SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Whether physicians, following the scruples of their individual consciences, may ethically respect the competent, voluntary and informed requests of terminally-ill patients to be relieved from their pain and suffering by assisting them in hastening otherwise inevitable death?

TABLE OF CONTENTS

Question Presented i

TABLE OF AUTHORITIES iv

INTEREST OF THE AMICUS CURIAE 1

ARGUMENT 2

THIS COURT SHOULD RECOGNIZE A RIGHT TO PHYSICIAN-ASSISTED SUICIDE FOR COMPETENT DYING PATIENTS 2

The Prevalence Of Death From Degenerative Disease Is A Modern Problem Not Addressed By Antiquated Laws 4

Classical Medicine Recognized A Patient's Right To Physician-Assisted Suicide 6

Petitioners Have Not Advanced Sufficient Interests To Overcome The Right Of A Terminally-Ill Patient To Assisted Death 8

Protocols and Guidelines May Be Imposed To Avoid The "Slippery Slope" 13

The Right of Competent, Dying Patients to Physician-Assisted Suicide is a Negative Right To Be Free from State Interference 18

CONCLUSION 20

TABLE OF AUTHORITIES

Cases

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) 13-14

Planned Parenthood of Southeastern Pennsylvania v. Casey, 502 U.S. 1056 (1992) 13-14

Roe v. Wade, 410 U.S.113 (1973) 13-14

Statutes

Revised Code of Washington 9A.32.030 10

New York Penal Law Section 60.06 10

Books & Articles

Amundsen, "The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots," Hastings Center Report (August 1978) 7

Angel, "Euthanasia in the Netherlands -- Good News or Bad?" New England Journal of Medicine 335:22 (Nov. 28, 1996) 1676 . . 15, 16-18 n.3

Bach, et al., "Physician Assisted Suicide and Euthanasia in Washington State," Journal of the American Medical Association 275:12 (March 27, 1996) 919 9

Bachman, et al., "Attitudes of Michigan Physicians and of the Public Toward Legalizing PhysicianAssisted Suicide and Voluntary Euthanasia," New England Journal of Medicine, 334:5 (Feb. 1, 1996) 303 9

Battin, The Death Debate: Ethical Issues in Suicide (1996) 4, 5

Battin, The Least Worst Death (1994) 15, 16

Beauchamp and Childress, Principles of Biomedical Ethics (4th ed. 1994) 2

Brock, "Voluntary Active Euthanasia," Hastings Center Report 22:2 (March-April 1992) 10 2

Delbruck, "Education for Suicide," Interview in Prism, a publication of the American Medical Association, 2 (1974) 20 20

Feinberg, "Voluntary Euthanasia and the Inalienable Right to Life," Philosophy and Public Affairs 7, no. 2 (Winter, 1978) 18

Gourevitch, "Suicide Among the Sick in Classical Antiquity," Bulletin of the History of Medicine 43 (1969) 501 7

Jamison, Final Acts of Love: Families, Friends, and Assisted Dying (1995) 12

Lee, et al., "Legalizing Assisted Suicide -- Views of Physicians in Oregon," New England Journal of Medicine 335:5 (Feb. 1, 1996) 310 9

Olshansky and Ault, "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases," in Timothy M. Smeeding, et al., eds. Should Medical Care Be Rationed By Age? (1987) 5

Omran, "The Epidemiologic Transition: A Theory of the Epidemiology of Population Change," Milbank Memorial Fund Quarterly 49 (4):509 (1971) 5

Owen, et al., "Cancer Patient's Attitudes to Final Events in Life: Wish for Death, Attitudes to Cessation of Treatment, Suicide and Euthanasia," Psycho-Oncology 3:1-9 (1994) . . . 19 n.4

Owsei and Temkin, Ancient Medicine: Selected Papers of Ludwig Edelstein, (1967) 11 7-8

Pijnenborg et al.,"Life-Terminating Acts Without Explicit Request of Patient," The Lancet 341 (May 8, 1993) 1196 . . . . . 16-18 n.3

Quill. M.D. "Death and Dignity: A Case of Individualized Decision Making." The New England Journal of Medicine 324:10 (March 7, 1991), 691 19

Shavelson, A Chosen Death: The Dying Confront Assisted Suicide, (1995) 12

Van der Maas et al., "Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995," New England Journal of Medicine 335:22 (Nov. 28, 1996) 16-18 n.3

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Other Authorities

"Deciding to Forego Life-Sustaining Treatment," President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, (March 1993) 2

Life Tables for the United States 1900-2050, Social SecurityAdministration, SSA Pub. No. 11-11534 5

OXFORD ENGLISH DICTIONARY (new ed.) 1

INTEREST OF THE AMICUS CURIAE

Bioethics, a learned discipline that arose approximately twenty-five years ago, deals "with ethical questions that arise as a result of advances in medicine and biology." OXFORD ENGLISH DICTIONARY (new ed.).

The bioethicists supporting Respondents in Vacco, et al. v. Quill, et al., No. 95-1858 ("Quill") and State of Washington v. Glucksberg, et al., No. 96-110 ("Glucksberg") are professors, lawyers, and medical doctors who have written and lectured extensively, and are considered among the nation's pre-eminent experts on the narrow issue before the Court.[1] Many of them hold multiple advanced degrees and occupy distinguished positions at universities and medical centers. They are identified at Appendix A.

The amicus group of bioethicists strongly believes that physicians, in carrying out their ethical duty to relieve the pain and suffering of their terminally-ill patients, should be legally permitted to accede to the desire of a patient to hasten death when the patient's decision is voluntarily reached, a patient is competent to make the decision, and the patient has been fully informed of the diagnosis and prognosis of an incurable, fatal disease which has progressed to the final stages. The amicus group also strongly believes that a physician may decline to honor such a request if it violates the physician's beliefs, morals or scruples or is contrary to the physician's medical judgment. The amicus group believes that the right to physician-assisted suicide should be recognized by this Court as a fundamental right, as the Court of Appeals for the Ninth

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[1] The bioethicists supporting Respondents have received the consent of the parties in Quill and Glucksberg to file this Amicus Curiae brief. The consents are being filed with the Court simultaneously with this brief.

Circuit ruled in Glucksberg. Moreover, the amicus group agrees with the Court of Appeals for the Second Circuit in Quill that the denial of physician-assisted suicide is a denial of equal protection to terminally-ill patients who do not have the option of hastening death by requesting the removal of life support systems.

These views are rooted in the four basic principles of biomedical ethics: autonomy, nonmaleficence, beneficence, and justice. Beauchamp and Childress, Principles of Biomedical Ethics (4th ed. 1994). From these principles, articulated in various ways in differing ethical systems, arise the two considerations most basic in medical care: the patient's fundamental right of self-determination and respect for the patient's interests. "Deciding To Forego Life-Sustaining Treatment," President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (March, 1983). Ethical requirements of respect for the patient's right of self-determination and respect for the patient's interests appropriately guide all care of patients, including the care of dying patients. Dan W. Brock, "Voluntary Active Euthanasia," Hastings Center Report 22:2 (March-April 1992) 10-22.

ARGUMENT

THIS COURT SHOULD RECOGNIZE A RIGHT TO PHYSICIAN-ASSISTED SUICIDE FOR COMPETENT DYING PATIENTS

Petitioners and their supporting amici have presented arguments that far exceed the understanding of physician-assisted suicide as approved by the Second and Ninth Circuit Courts. They argue that permitting physician-assisted suicide for terminally ill patients who seek to end their suffering in the final stages of degenerative diseases will lead to the involuntary killing of terminal patients and the healthy mentally ill and disabled.

These arguments are entirely flawed. The institution of safeguards to prevent abuse is necessary, but there is no basis to conclude that a voluntary practice limited to terminally-ill patients would be involuntarily applied, or that it could be imposed upon incompetents.

Petitioners and their amici also attempt to exploit taboos associated with suicide, citing, for example, instances of suicide among the depressed or mentally ill. The cases before this Court, however, do not involve sanctioning suicide of depressed or mentally-ill individuals.

Unlike other cultures, our language has but one word to describe self-inflicted death. The word "suicide" does not differentiate among the deaths of a teenager overcome by the struggles of adolescence, a middle-aged family man facing financial ruin and an eighty-year old cancer patient who seeks to avoid further protracted pain and suffering when her death is near. Unlike the first two tragic illustrations, there can be a sense of meaningfulness, emotional resolution, and communicative culmination, including gratitude for a life now complete, in the "suicide" of the dying patient who seeks both to avoid a bad death and to bring life to an inevitable but appropriate close. The dying patient may act to avoid or relieve suffering, and may also seek to meet death at a time and place of his or her own choosing, surrounded by those whom he or she trusts and loves, while still conscious and still capable of prayer and farewells. The right to seek a death which is both free of pain, but faced while conscious and alert, is not a trivial right, but one of great significance for many people.

The common term "suicide" carries strongly negative associations that have no bearing on the issue before the Court, but are largely derived from medieval attitudes towards violent self-destruction. Battin, The Death Debate: Ethical Issues in Suicide (1996). It would have been more accurate if the debate on

this issue had been joined on physician-assisted "death" as distinct from physician-assisted "suicide."

The Prevalence Of Death From Degenerative Disease Is A Modern Problem Not Addressed By Antiquated Laws

Petitioners stress the long tradition of prohibition against suicide, including penal laws dating to the founding of this country. But such laws derive from a time when death was rarely preceded by long periods of physiologically degenerative suffering. At the time the Constitution and the Bill of Rights were written and throughout the development of English common law, the process of dying was usually quick and more likely to be due to infectious disease. Medical intervention did little to prolong life, or to prolong the process of dying. The cases before the Court, however, involve degenerative death, a creature of modern medicine; they should therefore be decided on an historically clean slate. The Court, in finding for Respondents, would not be judicially mandating social change; it would be applying constitutional doctrines of protected individual rights to a new factual situation.

Epidemiologists identify four distinct periods to describe mortality and longevity in the history of mankind. In the Age of Pestilence and Famine, which extended from the dawn of human existence to approximately 1850, people died primarily from infectious and parasitic diseases, frequently exacerbated by famines and plagues. Advances in public sanitation, immunization and antisepsis in medicine gave rise to the Age of Receding Pandemics, which lasted until approximately 1920 and was accompanied by an increase in life expectancy. In the period from 1920 until 1960, the Age of Degenerative Man-Made Diseases, advanced surgical techniques, antibiotics, techniques for the administration of intravenous fluids and drugs, the development of respiratory support systems and improved therapeutic and diagnostic techniques further increased life expectancy. Omran, "The Epidemiologic Transition:

A Theory of the Epidemiology of Population Change," Milbank Memorial Fund Quarterly 49 (4):509-38 (1971). Epidemiologists characterize the current state of mortality and life expectancy, which arose in the mid 1960's, as the Age of Delayed Degenerative Diseases, in which the majority of people die at later ages from degenerative diseases, such as cancer, heart disease, stroke and neurological diseases. Olshansky and Ault, "The Fourth Stage of the Epidemiologic Transition: The Age of Delayed Degenerative Diseases," in Timothy M. Smeeding, et al., eds. Should Medical Care Be Rationed By Age? (1987) 11-43.

These epidemiological changes are partly illustrated by the changes in life expectancy. At the turn of this century, American life expectancy at birth was 46.5 years for males and 49 years for females. Life expectancy at birth is now approximately 72 years for males and 79 years for females. Life Tables for the United States 1900-2050, Social SecurityAdministration, SSA Pub. No. 11-11534. But these advances in life expectancy are associated with a fundamental change in the way we die: throughout the developed world of the late 20th century, including the United States, the majority of the population will die of degenerative disease. About a third of deaths are due to circulatory disease; another third are due to cancer; and the remaining third include degenerative conditions like neurological diseases and various forms of organ failure. The modern form of degenerative death is estimated to account for 70-80% of all deaths in the United States. Battin, The Death Debate, at 178.

Not only do these deaths from degenerative disease tend to occur at more advanced ages than has been characteristic of earlier periods of human mortality, but particularly in the case of cancer, they are often accompanied by protracted periods of pain and suffering before death, a phenomenon which occurred comparatively rarely until recent years. Prior to the development of modern antibiotics, the patient whose condition deteriorated severely or who became bedridden was likely to contract pneumonia

or other infections and die, thus being naturally spared the most difficult phases of end-stage disease.

The issue of physician-assisted suicide should be decided on the basis of present realities and not by reference to antiquated laws and customs adopted long before the modern form of degenerative death became prevalent. Neither the framers of the Constitution, nor any previous legal authorities, could have foreseen the way most people now die.

Classical Medicine Recognized
A Patient's Right To
Physician-Assisted Suicide

In Quill, petitioners cite one version of the Hippocratic Oath which contained the prohibition: "To please no one will I prescribe a deadly drug, nor give advice which may cause his death." Petitioners seem to suggest that the Oath has the force of law, but the version they cite also prohibits a number of medical practices clearly and uncontroversially recognized as legal, including surgery and charging fees for teaching medicine, as well as practices explicitly recognized as legal by this Court, such as abortion.

The Hippocratic Oath can only be understood in its historical context. At the time of Hippocrates, there was no prohibition against physician-assisted suicide in mainstream Greek medicine; the practice was subject to consultation and informed consent similar in intent to the protocols urged by medical professionals and bioethicists today. Thus, at the time of Hippocrates:

> ...the taking of poison was the most usual means of committing suicide [in terminal illness], and the patient was likely to demand the poison from his physician who was in possession of deadly drugs and knew that which brought about an easy and painless death. On the other hand, such a resolution was not taken without due deliberation, except perhaps in a few cases of great distress or mental strain. The sick man wished to be sure that further treatment would be of no avail, and to render this verdict was the physician's task. The patient, therefore, consulted with him, or urged his friends to speak to the doctor. If the latter, in such a consultation, confirmed the seriousness or hopelessness of the case, he suggested directly or indirectly that the patient commit suicide.... [I]n antiquity many physicians actually gave the patients the poisons for which they were asked.

Ancient Medicine: Selected Papers of Ludwig Edelstein, Owsei and C. Lillian Temkin, eds. (1967) 11-13. See also, Amundsen, "The Physician's Obligation to Prolong Life: A Medical Duty Without Classical Roots," Hastings Center Report (August 1978) 23, 26-27 (Hippocratic Oath is an "esoteric document that is often inconsistent with the larger picture of Greco-Roman medical ethics."); Gourevitch, "Suicide Among the Sick in Classical Antiquity," Bulletin of the History of Medicine 43 (1969) 501, 506-08.

Adherents of the Hippocratic school of medicine were strongly influenced by Pythagoras. Not unlike contemporary adherents of natural cures for disease, he eschewed many then-mainstream, accepted medical practices. The original Greek version of the Oath, quoted by the Quill petitioners, required the followers of Hippocrates:

> to teach them this art--if they desire to learn it -- without fee and covenant;
>
> * * *
>
> [to] apply dietetic measures for the benefit of the

sick according to my ability and judgment;

* * *

not [to] give to a woman an abortive remedy

* * *

not [to] use the knife....

Ancient Medicine at 6.

The text of the Hippocratic Oath has been modified many times through the ages. Contemporary versions, routinely adopted in medical-school graduation exercises and similar contexts (see text of Oath adopted by World Medical Association in 1948 reproduced at Appendix B), do not contain the prohibitions against surgery, abortion, or accepting fees for teaching medicine, and also omit the prohibition against physician-assisted suicide. In short, neither the Hippocratic Oath nor classical tradition provides a compelling ethical or professional prohibition of physician-assisted suicide.

Petitioners Have Not Advanced Sufficient Interests To Overcome The Right Of A Terminally-Ill Patient To Assisted Death

The States of New York and Washington argue that the government has an overriding interest in the preservation of life which is not subject to veto by the individual wishes of dying patients. Similarly, the American Medical Association and other amici supporting Petitioners contend that physicians are devoted to the healing arts and should not be involved in the termination of life.

Not only is there no adequate basis for either of these claims, but the AMA's position does not even reflect the views or practices of its constituency. In fact, physicians are divided about this issue, and many support the recognition of a patient's right to assistance and reject state interference in their right to practice medicine in a way they see as humane, compassionate, and respectful of the wishes of their dying patients. As reported in The New England Journal of Medicine, 60 percent of doctors in Michigan and 66 percent of doctors in Oregon -- two states in which this issue has been very widely discussed -- support legalizing assisted suicide for terminally-ill patients. Lee, et al., "Legalizing Assisted Suicide -- Views of Physicians in Oregon," New England Journal of Medicine 335:5 (Feb. 1, 1996) 310-315, at 311; Bachman, et al., "Attitudes of Michigan Physicians and of the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia," New England Journal of Medicine, 334:5 (Feb. 1, 1996) 303-309, at 303. In the State of Washington, 12 percent of physicians polled reported that they had been asked by their terminally-ill patients for prescriptions to hasten death, and of these, 24 percent had complied with such a request in the year prior to the study. Bach, et al., "Physician Assisted Suicide and Euthanasia in Washington State," Journal of the American Medical Association 275:12 (March 27, 1996) 919-925 at 919.

Assertions that doctors should have no role in death fly in the face of reality. All people eventually die, and the doctor's role appropriately includes ensuring that the patient's death occurs as humanely as possible. As Francis Bacon wrote, the physician's role is to help the patient "make a faire and easie passage."

The humaneness of a death is not only a matter of avoiding pain and physical suffering; it is also a matter of consonance with a patient's most basic values. For some patients, a death softened by the heavy use of painkillers or hastened by withholding or withdrawing life-sustaining treatment will be tolerable; for others such prospects are profoundly repugnant: these patients fear and

resent a death preceded by a period of obtundation, or in which their bodies slowly deteriorate from the ravages of a lethal disease. Not all patients will choose to die in the same way, even when death is imminent: some will prefer continued aggressive treatment, in the hope that they can beat the odds; some will prefer withdrawing or withholding specific forms of treatment; others will accept death as a consequence of escalating doses of morphine; still others will choose to forego nutrition and hydration; some will tolerate terminal sedation; but some strongly prefer a peaceful and humane death directly initiated while conscious and alert, facilitated by the assistance of a physician.

Physician-assisted suicide is not an option likely to be chosen by many. In the Netherlands, where assistance in dying is openly practiced and widely accepted, less than 3.5% of patients dying in a given year chose this manner of death. Yet it can be of very great moral and spiritual importance to those who make this choice. It may be the privilege of religious traditions to reject such a practice, as several of the Petitioners' amici point out, but it is not their privilege to assert that such an act on the part of a dying patient must be devoid of personal or spiritual significance.

Petitioners and their amici repeatedly assert the state's interest in preservation of life. This interest, however, is necessarily subject to careful qualification. Washington and New York have capital punishment statutes, permitting state-sanctioned death of otherwise healthy individuals. Revised Code of Washington 9A.32.030; New York Penal Law Section 60.06. The state, in times of war, sacrifices the lives of its most vital citizens to the national interest. Because the state approves of the deaths of individuals when it serves its interests, the state cannot advance an absolute objection to participation in death as an answer to claims that terminally ill patients have a right to seek and accept assistance from their physicians in suicide. The state clearly does have an interest in preventing suicide that is impulsive, aggressive, irrational, violent, or coerced, or where the suicidal impulse arises

from depression or other mental illness; but the state does not have an interest in preventing a competent patient, who is in any case facing death, from rationally and reflectively choosing what to that person is the preferable way of meeting death. It is the overly broad, unwarrantedly negative connotations of the term "suicide" that obscure this crucial distinction.

Virtually all data about the causes and characteristics of suicide and its relationship to mental illness, cited by several of Petitioners' amici, is data only about suicides in the former sense. Although rational, reflective suicides do occur in terminal illness, often assisted by physicians, they are virtually never reported as suicides, and it has thus been impossible to collect reliable data about these latter "suicides." Suicide is often said to be about the choice between life and death. Glucksberg and Quill, however, are not cases about patients choosing between life and death. They are about patients choosing death in a way that seems to them dignified, humane and more in keeping with their basic values, rather than what seems to them a less desirable and undignified death.

In a lengthy footnote, the Bioethics Professors' Amicus Curiae Brief Supporting Petitioners argues that physicians have no fear of prosecution if they prescribe drugs which a patient subsequently uses to commit suicide, provided the physician is not present when the patient takes the lethal medication. Brief For Bioethics Professors Amicus Curiae Supporting Petitioners at 15-16 n. 6.[2] Even if that were the case, maintaining such a status quo

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[2] We too, believe that this act should not be regarded as a criminal one, provided the prescription is provided at the voluntary request of a competent, fully informed patient. We particularly welcome these bioethicists' tacit recognition that some dying patients will prefer a directly-caused death and that some physicians will be willing to provide the means for it, since it counters the quite trivializing claim from other amici that the use of opiates, of

would be unsatisfactory. Physicians do not generally believe that they would be free from prosecution and they are often relunctant to assist patients who wish to die with dignity; it is at best a legally controversial claim. Because current statutes criminalizing assisted suicide contain no exemption for physicians, doctors are often constrained to abandon their patients at their time of greatest need. Even when a doctor prescribes the necessary drugs he or she often refuses to assist the patient in using the drugs. Unaided by professional assistance, an already suffering patient in the process of dying may take the medication improperly, survive, and undergo still more substantial suffering from unwanted, sublethal complications. Lonny Shavelson, A Chosen Death: The Dying Confront Assisted Suicide, (1995).; Stephen Jamison, Final Acts of Love: Families, Friends, and Assisted Dying (1995). Such profoundly unwanted events are not uncommon among "amateur" assisted suicides.

The bioethics professors supporting Petitioners erroneously believe that medical ethics is advanced by a practice where a physician and patient are encouraged to conspire covertly to circumvent the law, but where the patient is then denied medical assistance at the time of death and left to suffer the consequences of inadequate procedures. The bioethicists who are signators of the present brief believe strongly that medical ethics and trust in physicians are better served by physician-assisted suicide where the patient can have the care, comfort and treatment of his or her doctor at the time the patient acts to hasten death.

The argument of the Bioethics Professors in Support of Petitioners also misinterprets the medical facts of dying. Their brief, addressing the equal protection argument in Quill, attempts

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discontinuing life sustaining treatment, of withholding nutrition and hydration, and of terminal sedation are sufficient answers to the patient's distress.

to differentiate between patients on life support and those who are not. Those on life support are different, they argue, because of a bodily intrusion that could only have taken place with their consent, which consent they can withdraw at any time. They further claim that a terminally-ill person who is not on life support is differently situated for equal protection analysis because he or she is not being subjected to an ongoing physical intrusion. But this argument is erroneous. Both types of patients have had bodily intrusions for which they have given consent. A patient gives consent for a ventilator, or a feeding tube, and can then withdraw that consent and the bodily intrusion. Another patient gives consent for chemotherapy, a bodily intrusion which changes him or her unalterably, and ultimately leaves the patient in a condition of dying quite differently from that without the chemotherapy; yet the patient cannot withdraw that bodily intrusion, since it has already irreversibly occurred. Patients not connected to life support are therefore not free from bodily intrusion, and patients who are connected to life support do not die "naturally" if that support is removed. Once life has been prolonged with any sort of therapy, the mode of dying is unnatural; irreversible physical intrusion has already occurred. The Second Circuit Court of Appeals correctly rejected the claim that there is a rational distinction between refusing treatment and suicide.

Protocols and Guidelines
May Be Imposed To
Avoid The "Slippery Slope"

This Court has recognized the rights of individuals to make major life decisions regarding the integrity of their bodies, Roe v. Wade, 410 U.S.113 (1973); Planned Parenthood of Southeastern Pennsylvania v. Casey, 502 U.S. 1056 (1992), including the right of the terminally-ill to determine the end of their lives. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990). In all of these cases, the Court has carefully delineated the rights in question and stated that they are subject to reasonable regulation.

Roe v. Wade, supra, 410 U. S. at 163 ("a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health."); Planned Parenthood v. Casey, supra, 505 U.S. at 872 ("Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not follow at all that the State is prohibited from taking steps to ensure that the choice is thoughtful and informed"); Cruzan, supra, 497 U.S. at. 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements.").

Despite the history of caution by this Court in delineating rights with respect to life and death decisions, Petitioners and their amici contend that the Court's recognition of a right of competent, terminally-ill patients to obtain physician-assisted suicide will lead down a slippery slope such that its holding will lead to involuntary deaths or physician-facilitated deaths of the incompetent.

There is no basis to believe that physician-assisted suicide will lead to such abuses. Safeguards would obviously be devised to protect against abuse. Examples of such safeguards, the details of which are the appropriate concern of the states in regulating the exercise of patients' constitutionally-protected basic rights, are available both in this country and abroad. For example, the Oregon Death With Dignity Act, which by its terms is limited to competent adults who have been determined by the attending physician to be suffering from a terminal disease, requires two oral and one written request from the patient witnessed by two individuals to the effect that the patient is competent, acting voluntarily and is not being coerced to sign the request; requires the physician to inform the patient of his or her medical diagnosis and prognosis, the potential risks in, and probable results from, taking the medication; requires that the physician inform the patient of the feasible alternatives, including comfort care, hospice care, and pain control; requires that

the patient be referred to a consulting physician for confirmation of the diagnosis and determination that the patient is competent and acting voluntarily; requires that the patient be referred for counseling if appropriate; imposes a fifteen-day waiting period; and requires that the attending physician provide full documentation demonstrating compliance with the Act. It permits the patient to rescind the request at any time, in any manner.

Similarly, the Dutch guidelines for physician-assisted suicide require that the patient make a voluntary, enduring request; that the patient have adequate information about his or her disease, including alternative methods of treatment; that the patient's suffering be intolerable, in the patient's view, and irreversible, without alternatives for relieving the suffering that are acceptable to the patient; that the attending physician exercise due care in reviewing and verifying the patient's condition; that there be a consultation with a second, independent physician; and that the physician who provides assistance in hastening death file a written report of the death, which may not be reported as a natural death. Battin, The Least Worst Death (1994) at 131. Angel, "Euthanasia in the Netherlands -- Good News or Bad?" New England Journal of Medicine 335:22 (Nov. 28, 1996) 1676.

We believe such safeguards will provide patients clearly adequate protection against pursuing physician-assisted suicide from impulse, irrationality, depression, misinformation, manipulation, or coercion. They constitute reasonable means of assuring voluntary choice, of ruling out mental illness, of preventing mistaken diagnoses or faulty prognostications of terminal illness, of detecting familial, professional, or institutional pressures on the patient, of assuring that the practice actually serves the patient's interests, of protecting against the devaluation of members of minorities or disabled or medically dependent people, or in other ways protecting the patient's basic rights. Abuses are equally possible when treatment is withheld or withdrawn, when dosages of painkillers are used which foreseeably

depress respiration and so hasten death, when nutrition and hydration are withdrawn, when do-not-resuscitate orders are written, and when other commonplace strategies of "negotiated" death are employed. While there is no credible evidence that these possible abuses are in fact occurring to any significant degree, the safeguards to be erected for the protection of patients in the matter of physician-assisted suicide should operate to provide greater assurance of full voluntariness and full information, and, by requiring reporting, would allow surveillance of the practice to discover and penalize physicians or others who do not adhere to regulatory restrictions. Battin, "Voluntary Euthanasia and the Risks of Abuse," in Battin, The Least Worst Death, 163-181.

Petitioners and their amici claim that the experience of the Netherlands in permitting physician-performed euthanasia and physician-assisted suicide shows the substantial risks of a "slippery slope," where legalization or legal toleration of directly caused death leads to widespread unacceptable killing. Many of their claims are empirically false and grossly distorted. There is no evidence of conscious, competent patients being euthanasized against their will.[3]

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[3] In the majority of cases, a patient's current, explicit request, fitting the guidelines cited above, is in force at the time of assistance in suicide or euthanasia. In a fraction of cases (0.7%), there is no current explicit request; in about half of these cases (including all competent patients), either the decision was discussed with the patient earlier in the illness or the patient had expressed a wish for euthanasia if suffering became unbearable. In the other cases the patient was incompetent. In 91% of these cases, life was shortened by a week or less (in a third, 24 hours or less), and in the small number with longer life expectancy, the patient was evidently suffering greatly but verbal contact was no longer possible. Van der Maas et al., "Euthanasia, Physician-Assisted

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Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995," New England Journal of Medicine 335:22 (Nov. 28, 1996), 1699, 1701-1702. Loes Pijnenborg et al.,"Life-Terminating Acts Without Explicit Request of Patient," The Lancet 341 (May 8, 1993) 1196-1199.

New evidence from the Netherlands, based on studies which repeated the initial empirical studies of euthanasia and physician-assisted suicide known as the Remmelink report, show that reporting has increased and the frequency of cases regarded as problematic has decreased. The number of cases has increased in association with the aging of the population and an increase in the proportion of deaths from cancer, a function of the decrease in deaths from ischemic heart disease, but the proportion of requests granted has decreased. (Indeed, most requests for euthanasia or assistance in suicide are not granted.) Physician-assisted death does not involve patients whose illnesses are less severe, nor are there any signs that the decisionmaking has become less careful -- rather, there is more frequent consultation and better documentation. Van der Maas, supra, at 1703, 1705; Gerrit van der Wal et al., "Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands," New England Journal of Medicine 335:22 (Nov. 28, 1996), 1706-1711.

In the view of the researchers, "these data do not support the idea that physicians in the Netherlands are moving down a slippery slope," Van der Maas, supra, at 1705, a view echoed by the Executive Editor of the New England Journal of Medicine. Marcia Angel, MD., Editorial: "Euthanasia in the Netherlands -- Good News or Bad?" New England Journal of Medicine 335:22 (Nov. 28, 1996), 1676-1678, at 1677. Physician-assisted death continues to account for less than 3.5% of all reported deaths: thus the vast majority of patients dying in a given year do not choose it, and even the vast majority of cancer patients -- the most frequent

The Right of Competent, Dying Patients to Physician-Assisted Suicide is a Negative Right To Be Free from State Interference

In Glucksberg, the Ninth Circuit Court of Appeals held that physician-assisted suicide is a fundamental liberty right. This right to determine one's own mortality shares one important characteristic with other fundamental rights. Like the rights to vote or to worship, there is no requirement that the right be exercised. Joel Feinberg, "Voluntary Euthanasia and the Inalienable Right to Life," Philosophy and Public Affairs 7, no. 2 (Winter, 1978).

Similarly, under neither Glucksberg nor Quill would a physician be required to accede to a request for suicide assistance if the request violates the doctor's personal, medical or religious beliefs. The constitutionally-protected right asserted in these cases is, as bioethicists would put it, a negative right, a right not to be interfered with, a true liberty-right. Neither case asserts a positive right or claim-right, a demand that patients could make upon physicians whether physicians felt it medically or morally appropriate to respond or not. Thus, the full and appropriate scope of a physician's rights as well as a patient's rights would be recognized, since the physician would no longer be legally constricted in caring for a terminally-ill patient where that patient sought help in hastening death, though he or she would not acquire any new or unwanted obligation, and the full range of a patient's traditional, constitutionally-protected liberty rights of self-determination would be recognized in the new factual circumstance of the modern form of degenerative death.

---

diagnosis – do not. Yet it remains widely regarded as an important option even if one rarely needed or utilized.

Recognition of a protected right to seek and accept assistance in suicide from a willing physician is not only important for the comparatively small number of terminally-ill patients who might actually use it. Those patients who do not choose to exercise their right to physician-assisted suicide may gain comfort in the knowledge that the option exists if their suffering becomes intolerable. For many, this will make it possible to live fuller, more complete, lives during the process of dying, since they need not fear a bad death. Timothy E. Quill, M.D. "Death and Dignity: A Case of Individualized Decision Making." The New England Journal of Medicine 324:10 (March 7, 1991), 691-694. Indeed, the possibility of physician-assisted suicide, even if never used, may contribute positively to the quality of life for those facing death.[4]

The records before this Court contain the testaments of the individual, suffering plaintiff-patients -- all of whom died without the desired assistance of their physicians in terminating their pain and suffering and without the knowledge that the Courts of the Ninth and Second Circuits would respond to their anguished pleas. Their tales of agony could be reiterated many thousand times over, but may be summarized by the final note of the Nobel Prize-winning physicist, Percy Bridgman, who nearly 80 years old and suffering from terminal cancer, shot himself. His note stated:

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[4] A 1994 Australian study of cancer patients found that those who anticipated a role for the more active options of suicide and/or euthanasia in their own futures, compared to those who anticipated a future possible role for only the more passive options of wishing death to come early or ceasing all treatment, were more hopeful and reported a higher quality of life than patients who regarded them as out of the question. Owen, et al., "Cancer Patient's Attitudes to Final Events in Life: Wish for Death, Attitudes to Cessation of Treatment, Suicide and Euthanasia," Psycho-Oncology 3:1-9 (1994).

> It isn't decent for society to make a man do this thing himself. Probably this is the last day I will be able to do it myself.

Percy Bridgman, letter in Bulletin of the Atomic Scientists, quoted by Max Delbruck, "Education for Suicide," interview in Prism, a publication of the American Medical Association, 2 (1974) 20.

CONCLUSION

Affirmation of the decisions below will contribute to a more decent society, more respectful of patients' basic rights and interests in the light of the realities of the modern form of degenerative death. We strongly urge that they be affirmed.

Dated: New York, New York
December 9, 1996

Respectfully submitted,

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APPENDICES

APPENDIX A

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APPENDIX B

THE OATH OF HIPPOCRATES

I solemnly pledge to consecrate my life to the service of humanity. I will give respect and gratitude to my deserving teachers. I will practice medicine with conscience and dignity. The health and life of my patient will be my first consideration.

I will hold in confidence all that my patient confides in me. I will maintain the honor and the noble traditions of the medical profession.

My colleagues will be as my family. I will not permit considerations of race, religion, nationality, party politics, or social standing to intervene between my duty and my patient. I will maintain the utmost respect for human life.

Even under threat I will not use my knowledge contrary to the laws of humanity. These promises I make freely and upon my honor.

Approved by the World Medicine Association in 1948.

(52) (50)

Nos. 95-1858 and 96-110

Supreme Court, U.S.
DEC 10 1996
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON; CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., AND PETER SHALIT, M.D., Ph.D.,

Respondents.

On Writs Of Certiorari To The United States Courts Of Appeals and for the Second Circuit and for the Ninth Circuit

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BRIEF OF THE COALITION OF HOSPICE PROFESSIONALS AS AMICUS CURIAE FOR AFFIRMANCE OF THE JUDGMENTS BELOW

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43 pp

TABLE OF CONTENTS

Page

INTEREST OF THE *AMICUS CURIAE* 1

INTRODUCTION AND SUMMARY OF ARGUMENT 3

ARGUMENT 5

STATUTES THAT PREVENT THE TERMINALLY- ILL FROM OBTAINING MEDICAL ASSISTANCE TO HASTEN DEATH AND END SUFFERING ARE UNCONSTITUTIONAL 5

A. Terminally-Ill Patients Have A Powerful Interest In The Legal Ability To Hasten Imminent Death, Relieve Unendurable Suffering And Maintain Their Dignity In The Final Days Of Their Lives 5

1. All Pain And Suffering Cannot Be Relieved For All Terminally-Ill Patients 6

2. Terminal Sedation (Pharmacologically-Induced Coma) Does Not Obviate The Choice Of Physician-Assisted Suicide For Those Who Face Imminent Death 10

Page

B. The States' Interests Are Furthered By Permitting Terminally-Ill Individuals To Exercise This Personal Choice 15

1. Physician-Assisted Suicide Now Occurs Secretly Requiring That Appropriate Procedural Safeguards To Protect Terminally-Ill Patients From Coercion And Untoward Influence Be Established 15

2. The Availability Of Physician-Assisted Suicide Promotes The States' Interest In Preserving Life 20

3. The Availability Of Physician-Assisted Suicide Will Support The Integrity Of The Medical Profession 23

4. The Availability of Physician-Assisted Suicide Protects The Interests Of Family Members And Loved Ones 27

CONCLUSION 30

TABLE OF AUTHORITIES

CASES

Page

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STATUTES

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Or. Rev. Stat. § 127.800 (1995) 18

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a Group of Homosexual Men With
Advanced HIV Disease*, 6 J. Acquired
Immune Deficiency Syndromes 1069 (1993) 9

Page

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INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, a coalition of medical professionals who have extensive experience in providing hospice and palliative care to terminally-ill patients (the "Coalition") respectfully submits this brief in support of the Respondents.[1] All parties have consented to the filing of this brief, and the letters so stating have been filed with the Court.

Hospice and palliative care professionals participate in a system of care which employs an interdisciplinary team of physicians, nurses, home health aides, ethicists, chaplains, and bereavement counselors providing physical, emotional and spiritual support to people at the end of life. Hospice care does not involve medical interventions intended to defer death. Rather, the professionals, patients and their families treat death as an accepted part of life's continuum, and they work together to lend comfort, dignity and meaning to this final stage. In serving patients' goals and enhancing patients' ability to direct their lives, a principal role for the Coalition's members is providing relief from suffering. For many terminally-ill patients, suffering encompasses debilitating physical distress and psychological agony arising out of the loss of self-defined dignity, and living in conflict with spiritual and philosophical beliefs.

The Coalition believes that physician-assisted suicide must be an option of last resort and then only at the request of the terminally-ill patient. However, terminal illness alone does not justify choosing to hasten death. Aggressive hospice and palliative care -- also known as comfort care -- is highly effective for many patients. The medical profession and policymakers should enhance the availability of comfort care and establish it as

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[1] Appended to this brief is a list of the Coalition's members including their credentials and professional affiliations. The members of the Coalition speak from their collective personal experiences in the daily care of severely-ill and terminally-ill patients and do not speak for the institutions with which they are affiliated.

the standard of care for dying patients. However, hospice and palliative care does not always relieve suffering. For some patients, the pain can be so overwhelming that they cannot focus on anything beyond their unremitting suffering, and "life" becomes nothing more than their pain. Other patients appear to attain relief only with sedation so heavy that they cannot function, cannot interact with anyone, and "life" consists merely of lying inert, a condition that those patients reject as intolerable. The Coalition's members have treated patients whose distressing physical symptoms were too severe to be managed and have observed such patients wishing to hasten death. The Coalition believes that those desires can be fully competent and rational choices.

The legal availability of physician-assisted suicide in no way displaces the primacy and effectiveness of hospice and palliative care. As professionals, the Coalition's members intend to continue to respect the wishes of terminally-ill patients and to provide the best palliative care to each of them, including those who might choose a hastened death. Hospice and palliative care providers are particularly expert in determining whether a patient has explored all appropriate palliative treatments and whether the patient requests hastened death because of inadequate efforts to relieve suffering. Indeed, removing legal bans on suicide assistance will enhance the opportunity for advanced hospice care for all patients because regulation of physician-assisted suicide would mandate that all palliative measures be exhausted as a condition precedent to assisted suicide.

The Coalition attends to the physical, emotional and spiritual needs of terminally-ill patients and their families on a daily basis, and therefore is highly qualified to advocate on their behalf. As distinguished professionals in the fields of hospice and palliative care, the Coalition's members have a vital interest in presenting their terminally-ill patients with the broadest range of medical

options to alleviate suffering and promote dignified and meaningful living. These options must include, as a last resort for patients who judge their own suffering unendurable, prescribing medication that will enable those patients to hasten their own imminent deaths. These essential goals will be seriously undermined if this Court reverses the decisions of the Courts of Appeal for the Second and Ninth Circuits.

INTRODUCTION AND SUMMARY OF ARGUMENT

Both the Second and Ninth Circuits have struck down statutes that made it a crime to assist a person in committing suicide, as applied to physician-assisted suicide.[2] While the Second and Ninth Circuits adopted differing jurisprudential frameworks in reaching their conclusions, both courts examined, analyzed and balanced the respective interests of the individual and the State, but ultimately were not persuaded by the legitimacy and/or weight of the State's proffered justifications for the statutes. *See Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (holding that a New York statute criminalizing suicide

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[2] The terms "physician-assisted suicide," "assisted suicide," and "assisted death" are used interchangeably to refer to the practice in which a physician prescribes a lethal drug but the drug is actually administered by the terminally-ill patient. *See Compassion In Dying v. Washington*, 79 F.3d 790, 802 n.15 (9th Cir. 1996). Terms such as "physician-aid-in dying" or "euthanasia" refer to other medical actions which proximately bring about the death of a patient. Physician-assisted suicide -- as narrowly defined -- is the only practice at issue in this appeal, and the only practice about which the Coalition takes a position in this brief. Despite the adoption of this terminology for the purpose of this brief, the Coalition agrees with the Ninth Circuit that the phrase "physician-assisted suicide" is neither correct nor proper because the cause of death for the patient who seeks to hasten death is the underlying disease. *Id.* at 802. Indeed, it has been noted that, for the terminally-ill, "the choice is not between life and death, but choosing whether to die now or to die later." Jeremy A. Sitcoff, *Death With Dignity*, 29 J. Marshall L. Rev. 677, 680 (1996).

assistance violated the Equal Protection clause of the Fourteenth Amendment); *Compassion In Dying*, 79 F.3d 790 (holding that a Washington statute criminalizing suicide assistance violated the Due Process clause of the Fourteenth Amendment).

The Coalition defers to the Respondents to suggest a correct standard to be applied on these appeals and will not restate their arguments as to the proper mode of analysis. Rather, the Coalition will marshall and discuss empirical evidence of the circumstances surrounding the end of life that is relevant to the resolution of important issues raised by these appeals irrespective of which Constitutional constraints are applicable.

First, the experience of the Coalition's members makes clear, and the medical evidence confirms, that there are some terminally-ill patients whose suffering simply cannot be relieved, even with the best medical care (including terminal sedation).[3] For such patients, the ability to control the time and manner of death is an extremely important and highly personal matter. Accordingly, in assessing the individual's interests, the Court must recognize the limits of what palliative care can achieve and thus, the strong interests of such patients in relieving unendurable suffering.

Second, the observations of the Coalition's members reinforce their firmly held belief that criminalizing physician-assisted suicide does not serve the State's interests in: promoting life generally; preventing

---

[3] Terminal sedation refers to a medically-accepted treatment for terminally-ill patients whose suffering cannot be relieved by other means whereby intravenous drugs (usually barbiturates or benzodiazepines) are administered to induce a pharmacologic coma. Despite some imprecision in the empirical evidence, it has been estimated that between 5% and 52% of dying patients entering home palliative care units have been terminally sedated. Paul Rousseau, *Terminal Sedation In The Care Of Dying Patients*, 156 Archives Internal Med. 1785 (1996).

abuse, mistake and coercion in decisions to hasten death; preserving the integrity of the medical profession; and protecting the dying individual's loved ones. Assisted suicide occurs despite state laws. Were physician-assisted suicide legal, appropriate procedural safeguards could be enacted to ensure that the individual has explored all appropriate palliative care options and is not choosing a hastened death as a result of inadequate efforts to relieve pain and suffering, or any untoward influence. In assessing the legitimacy and/or weight of the States' interests, the Court should consider the experience of palliative care experts and the medical evidence set forth herein which demonstrates that the States' interests are not undermined by permitting physician-assisted suicide.

ARGUMENT
STATUTES THAT PREVENT THE TERMINALLY-ILL FROM OBTAINING MEDICAL ASSISTANCE TO HASTEN DEATH AND END SUFFERING ARE UNCONSTITUTIONAL

As shown below, someone who is suffering grievously on his or her deathbed has a powerful interest in accelerating the time of death. Conversely, the States' proferred interests are furthered by legalizing physician-assisted suicide. Accordingly, the judgments below should be affirmed.

A. Terminally-Ill Patients Have A Powerful Interest In The Legal Ability To Hasten Imminent Death, Relieve Unendurable Suffering And Maintain Their Dignity In The Final Days Of Their Lives.

Hospice professionals are committed to the tenet that patients facing imminent death should be treated compassionately and that they should be able "to make as many choices as possible for themselves -- both in living what is left of life and in dealing with fatal illness."

National Hospice Organization ("NHO") *Amicus* Br. at 3. Accordingly, hospice professionals -- including the NHO -- believe that a terminally-ill patient is entitled to the best palliative care available but is also entitled to the legal option of refusing any medical intervention, including the provision of artificially-supplied hydration and nutrition. *See Id.; Cruzan v. Director*, Missouri Dep't of Health, 497 U.S. 261 (1990). The personal decision of a terminally-ill and suffering individual to hasten death with medical assistance is entirely consistent with hospice philosophy that respects patient autonomy and promotes compassionate treatment. Physician-assisted suicide should be permitted in the rare cases where medical treatments (including terminal sedation and pharmacologically-induced coma) cannot eliminate a dying individual's pain and suffering or are not desired by the patient. Thus, physician-assisted suicide is a compassionate response to an individual's powerful interest in controlling the time and manner of his or her death.

1. All Pain And Suffering Cannot Be Relieved For All Terminally-Ill Patients -- In its medical experience, the Coalition has encountered dying patients whose suffering and misery cannot be relieved with the most aggressive palliative measures. In the face of diseases which destroy the body and rob the spirit, such patients have a powerful interest in obtaining medical assistance to hasten their imminent death.

Hospice professionals know that hospice care can relieve or lessen the physical pain of most terminally-ill patients and that hospices generally provide better palliative care than do non-hospice treatment programs. *See, e.g.*, Jamie H. Von Roenn, *Physician Attitudes and Practice in Cancer Pain Management*, 119 Annals Internal Med. 121 (1993) (reporting that 90% of cancer patients in hospice units report pain relief, whereas 50% to 80% of cancer patients do not have adequate pain control outside

the hospice environment). Nevertheless, all hospice professionals, including the NHO, now acknowledge that irrespective of the efficacy of palliative medicine, there are some patients whose physical pain cannot be relieved adequately. *See NHO Amicus* Br. at 8; Howard Brody, *Assisted Death: A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384, 1385 (1992) ("[I]n a small percentage of cases palliative efforts will fail"); Larry Beresford, *Hospice and the End of Life Debate*, 9 Cal. Hospice Rep. (Summer 1991), at 8 ("Everybody who has worked in hospice for very long knows a handful of cases where the patient's suffering was simply untreatable.").

Hospice professionals also know, and the Second and Ninth Circuits have recognized, that the suffering of the terminally-ill is not merely physical. *See Quill*, 80 F.3d at 729-30; *Compassion In Dying*, 79 F.3d at 812. The mental anguish and personal degradation that precedes death are often more severe than the physical pain. Patients may experience suffering associated with mechanical life-sustaining apparatuses, loss of control over bodily functions, and inability to care for themselves and to participate fully in life activities. In spite of the best palliative care, the prolonged physical deterioration and decay of body, skin, bowels and mind can lead to the reality of existence as a living carcass that can become repugnant to the most caring and stalwart of families, and to the lingering patients themselves. For these patients

> [r]elinquishing control and independence, or compromising personal standards of behavior and "quality of life," may be experienced as worse than death. Ironically, accelerating death becomes a way to preserve the self.

Susan D. Block & J. Andrew Billings, *Patient Requests To Hasten Death*, 154 Archives Internal Med. 2039, 2043 (1994).

Likewise, one nurse practicing home hospice care has described the nature of terminal suffering as follows:

> For many, the pivotal issue is quality of life. Although free of pain, they hate living with the spinal cord compression that left them incontinent of bowel and bladder. Or they hate the inhuman substance that pours from their tumor and onto their clothes, into their hair, onto their furniture. They would rather be dead than live with the brain tumor that has locked them inside a motionless, aphasic body. Like most hospice nurses, my cache of horror stories is endless.

Theresa M. Stephany, *Hospice-Assisted Suicide*, 11 Home Healthcare Nurse 50 (1993). For such patients, accelerating the dying process is the only available relief from suffering that medical professionals can provide.

In addition, terminally-ill patients may have religious or spiritual convictions that render their suffering even more difficult to bear. *See, e.g.*, Timothy E. Quill, *A Midwife Through The Dying Process* (The Johns Hopkins University Press 1996) at 14 ("In Zen Buddhism, how one dies has considerable bearing on how one is reborn in the next life. Being at peace is the best one can hope for and dying in agony puts one at risk.").

As death becomes more imminent, pain and suffering become progressively more difficult to treat. *See* Nathan I. Cherny & Russell K. Portenoy, *Sedation in the Management of Refractory Symptoms*, 10 J. Palliative Care 31 (1994). For example, terminal agitation (which is also known as terminal restlessness) is a well-documented and heart-wrenching condition that precedes death for many patients, particularly those afflicted with cancer. *See generally* Ian N. Back, *Terminal Restlessness in Patients with Advanced Malignant Disease*, 6 Palliative Med. 293 (1992). Patients suffering from terminal agitation are generally unable to remain still and exhibit motor restlessness such as involuntary muscle twitching or volitional tossing and turning. Terminally agitated patients are also worried, uneasy or anxious. *Id.* This is a particularly distressing

condition for the patient to bear and for his or her loved ones to witness.

In concluding that, in some limited situations, physician-assisted suicide may be the "least terrible of a set of difficult alternatives," hospice professionals have acknowledged the powerful roles that physical distress and the loss of dignity and personal autonomy play in creating an intolerable state of suffering that no medical treatment will alleviate. Block *et ano.*, 154 Archives Internal Med. at 2045. For some patients, such intense suffering is unbearable and leaves them no option but to request medical assistance in hastening their inevitable deaths. *See* Anthony L. Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 924 (1996) ("Patients who request [physician-assisted suicide] . . . are worried about losing control, being a burden, being dependent, and losing dignity."); Clive Seale & Julia Addington-Hall, *Euthanasia: Why People Want To Die Earlier*, 39 Soc. Sci. & Med. 647 (1994) (reporting that requests for suicide rise as levels of distress and dependency increase); Robert J. Blendon *et al.*, *Should Physicians Aid Their Patients In Dying?* 267 JAMA 2658 (1992) (reporting that not wishing to be dependent upon machines and not wanting to continue living unable to perform most daily activities are reasons frequently cited by terminal patients for hastening death).

Numerous public opinion surveys demonstrate that the majority of Americans favor respecting autonomous decisions by terminally-ill patients to control the manner and circumstances of their death, and support legalization of physician-assisted suicide. *Compassion In Dying*, 79 F.3d at 810 (citing survey data). *See also Knowledge and Attitudes Related to Hospice Care* (Gallup Poll Commissioned by the NHO (1996)). Individuals are particularly likely to favor physician-assisted suicide when they are afflicted with a debilitating and terminal disease. *See* Brett Tindall *et al.*, *Attitudes to Euthanasia and*

Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease, 6 J. Acquired Immune Deficiency Syndromes 1069 (1993) (reporting that "a large proportion of subjects with severe HIV disease in this sample wanted to have the option of euthanasia available should they become severely ill"). Accordingly, the beliefs of the American people are consistent with the experience of the Coalition in dealing with terminal patients on a daily basis, which in turn lead to the inescapable conclusion that dying individuals have a powerful interest in controlling the timing and manner of their death.[4]

2. Terminal Sedation (Pharmacologically-Induced Coma) Does Not Obviate The Choice Of Physician-Assisted Suicide For Those Who Face Imminent Death. -- Opponents of physician-assisted suicide erroneously argue that terminal sedation by use of barbiturates or benzodiazepine to induce unconsciousness obviates the need for assisted suicide. *See, e.g.*, Am. Geriatrics Soc'y *Amicus* Br. at 25. The fact is that terminal sedation has not been proven to eliminate either the pain, suffering or distress of dying patients. Moreover, many patients and the family members who are caring for them at home find the reality of the patient's lingering for days to weeks in a medically-induced comatose state to be antithetical to a good and dignified death. Finally, and ironically, the fact that terminal sedation is practiced by some medical professionals undermines arguments against physician-assisted suicide inasmuch as the practice may also have the "double effect" of hastening death.

Medical professionals have agreed that terminal sedation may be used with the intent to: (1) relieve physical pain; (2) produce an unconscious state before the

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[4] The fact that state legislatures have not repealed ancient statutory prohibitions against physician-assisted suicide is only the weakest kind of contrary evidence of public will, especially where such statutes have gone unenforced for generations.

withdrawal of artificial life support; or (3) relieve non-physical suffering. Robert D. Truog *et al.*, *Barbiturates in the Care of the Terminally-ill*, 327 New Eng. J. Med. 1678 (1992). Terminal restlessness, for example, is commonly treated by putting the patient into a pharmacologic coma. Generally, nutrition and hydration are also discontinued when the patient is under sedation, and the patient then dies of starvation and/or dehydration. Physicians recommend such treatment to dying patients and their families on the grounds that the sedated state will relieve the individual's suffering and enable him or her to die peacefully and "naturally."

Unfortunately, while a terminally-sedated patient exhibits an outwardly peaceful appearance, medical science cannot verify that the individual ceases to experience pain and suffering. To the contrary, studies of individuals who have been anaesthetized (with the same kinds of drugs used in terminal sedation) for surgery (and who are in a deeper comatose state than terminally-sedated patients since their breathing must be sustained by a respirator) have demonstrated that painful stimuli applied to the patient will cause a significant increase in brain activity, even though there is no external physical response. *See, e.g.*, Orlando R. Hung *et al.*, *Thiopental Pharmacodynamics: Quantitation of Clinical and Electroencephalographic Depth of Anesthesia*, 77 Anesthesiology 237 (1992).

Other studies have established that anesthetized patients may continue to perceive and remember events that occur around them despite appearing "unconscious" to others. *See, e.g.*, R.C. Cork *et al.*, *Is There Implicit Memory After Propofol Sedation?* 76 British J. Anesthesiology 492 (1996). Thus, terminally-sedated patients may continue to suffer pain and be aware of their dying condition without being able to communicate their suffering and fears. One can hardly imagine a more distressing and dehumanizing way to die.

Even assuming *arguendo* that terminal sedation could be proven to relieve physical pain and eliminate awareness of death, the treatment is repugnant to many patients who do not wish to prolong the inevitable by lingering in a comatose state. The experience of a terminally-ill cancer patient, Renee Sahm, graphically illustrates the concerns of patients who reject terminal sedation:

> A week later [after Renee's discharge from a hospice unit], Renee's hallucinations and panic set in. Scorpions crawled about her room; over and over, she shouted in fear during an imagined plane crash. Renee tossed violently about in her bed while friends and her attendant provided a twenty-four hour watch -- knowing that the only alternative to the hallucinations would be heavy pharmacologic sedation. But while Renee had still been coherent, she'd spoken adamantly against this very sedation. Her friends agreed: Since she was slipping in and out of periods of coherence, heavy sedation might deprive Renee of important final lucid moments.

Lonny Shavelson, *A Chosen Death*, (Simon & Schuster 1995) at 211.

There are many other valid reasons for rejecting terminal sedation as a sufficient substitute in all cases for physician-assisted suicide. Some patients refuse terminal sedation because of the burden it places on their loved ones, who are often called upon to witness the disintegration of their family member or friend by caring for the comatose body until death. Such care may include frequent turning, care of odorous bed sores, and management of urinary and fecal incontinence. Ironically, a compelling description of the emotional suffering inflicted upon family and friends of terminally-sedated patients comes from a physician who opposes the legalization of physician-assisted suicide:

> Family members caring for a dying loved one who is in the throes of dying, perhaps moaning incomprehensibly or breathing noisily, may find themselves suffering in true compassion. And they may be in doubt, guilt, and confusion: wishing for the death of a loved one whom they will miss -- indeed already miss -- and who they wish was either well and back with them or peacefully gone. This is made all the more poignant and intense by the near-universal sleep deprivation that accompanies this experience.

Ira R. Byock, *Consciously Walking the Fine Line: Thoughts on a Hospice Response to Assisted Suicide and Euthanasia*, 9 J. Palliative Care 25, 27 (1993). Despite witnessing such suffering, Dr. Byock nonetheless questions whether physician-assisted suicide is preferable. The Coalition submits that each dying patient -- not the State or the patient's physician -- must answer this question for himself or herself. Respecting the dignity of dying patients means respecting that individual's deeply personal choice about how to live in his or her final days. *See Planned Parenthood v. Casey*, 505 U.S. 833, 851 (1992) ("These matters, involving the most intimate and personal choices a person may make in a lifetime . . . are central to the liberty interest protected by the Fourteenth Amendment.")

It is also significant that terminal sedation is advocated and practiced by the most vehement opponents of physician-assisted suicide even though the patient's death may be hastened. *See, e.g.*, Am. Med. Ass'n *Amici* Br. at 6; Ira R. Byock, *The Euthanasia/Assisted Suicide Debate Matures*, Am. J. Hospice & Palliative Care, Mar./Apr. 1993, at 8, 10. The proffered justification for terminal sedation is based upon the "principle of double effect," whereby medical treatments with the intended effect of relieving pain and suffering are permissible even though a side effect is the hastening of death. Nathan I. Cherny *et ano.*, 10 *J. Palliative Care* at 36.

The Coalition submits that, as a practical matter, the only distinction between terminal sedation and physician-assisted suicide is that the period of time between administration of the lethal agent and death is condensed in physician-assisted suicide. Ascertaining the "intent" of the physician who advocates terminal sedation is a complicated, if not altogether impossible, task. *See* Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039 (1993). Indeed, medical professionals know that the practice of terminal sedation is one method of assisting patients in hastening death:

> Justification based on the principle of double effect requires that the clinician intend only to relieve the patient's suffering and not to cause death. When barbiturates or opioids are administered to the terminally-ill, however, both effects are often seen as desirable. The hastening of death in these cases is sometimes referred to as "a blessing in disguise." Justification by double effect may therefore function as a "fig leaf" for euthanasia.

Truog *et al.*, 327 New Eng. J. Med. at 1680. *See also* Franklin G. Miller & Howard Brody, *Professional Integrity and Physician-Assisted Death*, 25 Hastings Ctr. Rep. 8, 12 (1995) ("[I]t is not clear that relieving terminal suffering by inducing unconsciousness, which may hasten death, is morally superior to voluntary physician assisted death.").

The distinction between terminal sedation and physician-assisted suicide further blurs when one considers that the criteria for terminal sedation are similar to those proposed for physician-assisted suicide. *Compare* Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives Internal Med. 1785 (1996) (Prior to the initiation of sedation, clinicians must ascertain the need for sedating therapy, including the presence of a terminal disease with impending death, exhaustion of all other palliative treatments, agreement by patient and family members of the need for sedation, and a current do-not-

resuscitate order.) *with infra*, pp. 17-18 (Carefully considered guidelines for physician-assisted suicide recommend that the primary care physician document: a terminal diagnosis; a judgment that the patient is mentally competent and not suffering from depression; that high-quality palliative care and hospice care, psychological care and other treatment have been made available to the patient; and that the patient's decision was freely and independently made, without coercion or financial duress.).

B. The States' Interests Are Furthered By Permitting Terminally-Ill Individuals To Exercise This Personal Choice.

The Coalition is convinced that assisted-suicide already exists in fact, far beyond the power of medical professionals, this Court or any legislature to prevent. Many terminally-ill individuals now carry out acts of suicide with the assistance of loved ones. Likewise, there is empirical evidence that medical professionals already assist in acts of suicide cloaked in the sanctity of the physician-patient relationship. Recognizing these unvarnished facts, the question before the Court then, is whether trained medical professionals should be permitted legally to provide a full range of options to terminally-ill patients. For the reasons set forth below, the Coalition submits that medical professionals and terminally-ill patients should be permitted to explore all options for the patient, including the hastening of death, and that this would further the expressed state interests.

1. Physician-Assisted Suicide Now Occurs Secretly Requiring That Appropriate Procedural Safeguards To Protect Terminally-Ill Patients From Coercion And Untoward Influence Be Established. -- Physician-assisted suicide, although presently illegal in most states, is nonetheless a common practice, motivated by the sincere belief of many doctors that it is imperative

for some patients. This practice should be regulated not outlawed.

Surveys demonstrate that there is history of physicians helping their patients to die.[5] In a blind study of primary care physicians in the State of Washington, 26% of doctors surveyed reported that they had received one or more explicit requests for physician-assisted suicide and/or euthanasia, and 12% of doctors surveyed had received such requests within the last year. Anthony L. Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State*, 275 JAMA 919, 920 (1996). Physicians provided a lethal prescription to 24% (38 of 156) of the patients who requested physician-assisted suicide. *Id.* at 922. *See also* David J. Doukas *et al.*, *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clinical Oncology 1055 (1995) (reporting that 40% of responding Michigan oncologists reported patient-initiated requests of both assisted suicide and active euthanasia, 18% reported active participation in assisted suicide and 4% reported participation in euthanasia); L. Slome *et al.*, *Physicians' Attitudes Toward Assisted Suicide in AIDS*, 5 J. Acquired Immune Deficiency Syndrome 712 (1992) (reporting that 23% of responding physicians who treat AIDS patients would likely grant a patient's request for assistance in hastening death). Thus, medical professionals assist in suicide in spite of statutes criminalizing the practice -- even in states like Michigan where public scrutiny is heightened by media attention to the practice.

The reality of physician-assisted suicide undercuts the States' argument that their statutes effectively control

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[5] Establishing empirical evidence of physician-assisted suicide is impeded by the fact that the practice is illegal in most states. Accordingly, researchers have been forced to conduct blind surveys of physicians, since an open admission could subject the respondent to the risk of criminal prosecution.

the practice. Evidence of substantial defiance of the law, and the obvious conclusion that the States are powerless to prevent it, renders statutes prohibiting assisted suicide merely symbolic, essentially defended as a form of state propaganda of one moralistic view, rather than a realistic regulation of behavior. *See Carey v. Population Services Int'l*, 431 U.S. 678, 715 (1977) (Stevens, J., concurring). The challenge then, is to transform those factual observations into a mandate for constructive governance, upholding the individual's liberty interest in the control of his or her own physical being, while at the same time guarding against irresponsible decisions to undertake suicide.

Carefully considered guidelines for assuring just that result have already been promulgated by medical professionals. For example, in the San Francisco metropolitan area a network of ethics committees promulgated the *BANEC-Generated Guidelines for Comprehensive Care of the Terminally Ill.* Bay Area Network of Ethics Committees, September 1996. Those guidelines provide for safeguards and documenting procedures as part of a high general-care standard for patients with terminal illnesses. The guidelines emphasize that the primary care physician must make an initial referral to a hospice program or to a physician experienced in palliative care. *Id.* at 2. They also recommend that the primary care physician document: (1) a terminal diagnosis; (2) a judgment that the patient is mentally competent and not suffering from depression; (3) that the finest available palliative care and hospice care has been made available to the patient; and (4) that the patient's decision was freely and independently made, without coercion or financial duress. *Id.* at 3. A second, documented opinion from another physician who should have expertise in palliative end-of-life care is also recommended. *Id.* To ensure that the decision was voluntary, the patient must execute a written consent form

twice, with a two-day waiting period between signatures. *Id.* at 3-5. Finally, the guidelines provide for a state registry of all documented cases of assisted suicide. *Id.* Similar careful standards and safeguards have been developed in the States of Michigan and Oregon. Michigan Commission On Death and Dying, *Final Report*, (June 1994) (appending a Michigan Model Statute Supporting Aid-In-Dying); Or. Rev. Stat. § 127.800 (1995) (describing procedural safeguards in Oregon's Death With Dignity Act). *See also* Sitcoff, 29 J. Marshall L. Rev. 677; Charles H. Baron *et al.*, *A Model State Act to Authorize & Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996); Franklin G. Miller *et al.*, *Regulating Physician-Assisted Death*, 331 New Eng. J. Med. 119 (1994); Timothy E. Quill *et al.*, *Care of the Hopelessly Ill: Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380 (1992).

Such guidelines, which would properly be enacted by state legislatures, are necessary because, *inter alia*, they minimize the possibility of physician-assisted suicide for those patients who are depressed such that they lack the mental competency to decide whether to accelerate their death. Although depression can be a major factor in an individual's decision to end his or her life and can in some instances impair competency, empirical studies demonstrate that not all patients who express an interest in physician-assisted suicide suffer from depression that impairs competency. William Breitbart *et al.*, *Interest In Physician-Assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238, 241 (1996). ("[O]ur data also suggest . . . that not all of patients' interest in physician-assisted suicide is the result of depression."). Palliative care professionals, including psychiatrists, know that it is normal for a terminally-ill and suffering individual to be unhappy, but these professionals have the skill and experience to distinguish between patients who

can make rational and competent decisions and those who cannot.

Moreover, the proposed guidelines would also limit physician-assisted suicide to the terminally-ill. Although some briefs submitted to the Court have raised doubts as to the ability of the medical profession to estimate the life expectancy of their patients, physicians and hospice professionals in fact routinely make just such terminal diagnoses. Indeed, the threshold criterion for enrollment of hospice patients into the federal Medicare and state Medicaid benefit programs is a prognosis of six months or less. 42 U.S.C.A. §§ 1395(d)(d), 1395(f)(i), 1395(x)(dd)(3)(A) (West Supp. 1996); 42 C.F.R. §§ 418.22, 418.200 (1996); *see also NHO Medical Guidelines For Determining Prognosis In Selected Non-Cancer Diseases*, at 2-3 (1995) (parameters used to determine whether a patient is appropriate for hospice care and eligible for Medicare/Medicaid Hospice Benefit, based on terminal condition).[6] Accordingly, the suggestion that terminal diagnoses are impossible is simply incorrect and flies in the face of routine medical prognostication.

The Coalition submits that the proposed guidelines, which should be enacted by state legislatures, are sufficient to prevent abuse, coercion or improper decision-making. This is due in part to the nature and philosophy of hospice care, and the resulting relationships between hospice professionals and their patients. The parade of horribles envisioned by opponents of physician-assisted suicide is greatly exaggerated. Under a regulated system, a professional would be required to assess whether such patient was experiencing pain, fear or depression which

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[6] The NHO's newly-issued Second Edition Guidelines offers procedural standards to make the same determination, on roughly the same criteria, but now labels it a "life limiting" rather than a "terminal" condition. *See NHO Medical Guidelines For Determining Prognosis In Selected Non-Cancer Diseases* (2d ed. 1996) at 6-7.

could be alleviated, thereby relegating suicide to an alternative of last resort -- to be used only when all other palliative and psychosocial interventions have been tried and have failed.

2. The Availability Of Physician-Assisted Suicide Promotes The States' Interest In Preserving Life. -- This Court has acknowledged the States' interest in preserving human life. *See, e.g., Cruzan*, 497 U.S. at 282. The Coalition submits that physician-assisted suicide accords with the principle of promoting life because affording a patient the choice to hasten death, should his or her suffering become intolerable, can sustain and preserve that individual's will to live.

Numerous studies have revealed that a significant reason terminally-ill individuals contemplate suicide is the feared loss of control often associated with the progression of many terminal diseases. *See supra* pp. 9-10. Proscribing physician-assisted suicide enhances this sense of impotence by discouraging dying patients from engaging in meaningful discussions with their doctors about the very thoughts that weigh heavily on their minds. Thus, fears about the tolerability of their final days are internalized, rather than shared with experienced professionals. Saddled with such fears, many patients conclude that the only method of preserving self-determination and human dignity is to take their own lives while they are physically and mentally capable of doing so, long before they are disabled by their disease, and often before all possible palliative options have been fully explored. *See* Back *et al.*, *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA at 922 (1996); Timothy R. Coté *et al.*, *Risk of Suicide Among Persons With AIDS*, 268 JAMA 2066 (1992); Kay Longcope, *AIDS Related Suicide Up*, Boston Globe, Mar. 17, 1990, at A25.

Allowing doctors to help a mentally competent patient avoid a prolonged and often painful death would

alleviate the some of fear and desperation inherent in a patient's confrontation with his or her imminent mortality. In fact, those doctors who have agreed to assist a patient in ending his or her life have acknowledged that their articulated willingness to provide choice in the face of death gave their patients the security and reassurance to continue to live meaningful lives. For example, Dr. Quill describes his agreement to prescribe barbiturates for a long-time patient and close friend dying of leukemia as follows:

> In our discussion, it was apparent that she was having trouble sleeping, but it was also evident that the security of having enough barbiturates available to commit suicide when and if the time came would leave her secure enough to live fully and concentrate on the present. It was clear that she was not despondent and that in fact she was making deep, personal connections with her family and close friends. I made sure that she knew how to use the barbiturates for sleep, and also that she knew the amount needed to commit suicide. We agreed to meet regularly, and she promised to meet with me before taking her life, to ensure that all other avenues had been exhausted. I wrote the prescription with an uneasy feeling about the boundaries I was exploring -- spiritual, legal, professional and personal. Yet I also felt strongly that I was setting her free to get the most out of the time she had left, and to maintain dignity and control on her own terms until her death.

Timothy E. Quill, *Death & Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991). *See also* Betty Rollin, *Last Wish* (Linden Press/Simon & Schuster 1985).

Moreover, many patients who are prescribed lethal medications never actually take them. Back *et al.*, 275 JAMA at 922. And, most of those patients who do use

the drugs to hasten their death do not do so immediately upon receiving them, but rather choose to live longer. *Id.*

The experience of Pierre Nadeau is illustrative on this point. Pierre became deeply depressed when he discovered he was dying of AIDS, and was obsessed with suicide. After his friend Stephen promised that he would help Pierre die if his sickness prevented him from doing it on his own, his depression lifted. When asked whether he would have committed suicide if, at the time he wanted to kill himself, the means had been readily available and legal, Pierre responded, "No . . . . Actually, if it was that easy I would wait, because I'd know that I could do it whenever I wanted to." Shavelson, *A Chosen Death* at 54. *See also* Gina Kolata, *AIDS Patients Seek Solace In Suicide But Many Risk Added Pain In Failure*, N.Y. Times, June 14, 1994, at C1 (reporting that a dying patient who had gathered sufficient lethal drugs but did not use them stated, "Having the means to kill [myself] . . . has diminished my horror, as though I was facing an enemy on a battlefield stark naked and now I have armour.").

In opposing physician-assisted suicide, the States fail to recognize that patients who are denied this personal choice may also be denied the opportunity for positive end-of-life experiences. Such patients may spend their last days worrying about how they are going to hoard enough sleeping pills, or other lethal drugs; hide them from their health care professionals and loved ones until the point when their condition becomes intolerable; and ascertain what method of suicide will end their suffering, rather than intensify it if the attempt fails. A patient may even choose to experience pain in order to create a stash of narcotics to be used later to induce death. The anxiety felt by patients contemplating suicide is enhanced by the knowledge that a botched suicide attempt "may cause [additional] physical suffering, shame, humiliation, and a deepened sense of helplessness." Block *et ano.*, 154

Archives Intern Med. at 2040; Quill, 324 New Eng. J. Med. at 693.

The potential for medical assistance in hastening death can actually provide patients with the sense of control and comfort needed to spend their final days meaningfully examining spiritual issues, and strengthening bonds or resolving conflicts with loved ones -- precisely the type of positive end-of-life experiences that the States incorrectly argue would be diminished by the availability of physician-assisted suicide.

3. The Availability Of Physician-Assisted Suicide Will Support The Integrity Of The Medical Profession. -- The Coalition believes, and the Ninth Circuit has found, that outlawing physician-assisted suicide may diminish the public's trust and respect for the medical profession. *Compassion In Dying*, 79 F.3d at 827. Accordingly, the Coalition submits that each medical professional should be permitted to decide for himself or herself (consistent with appropriate guidelines) whether to assist a terminally-ill patient in accelerating death, and that such assistance is consistent with the proper role of medical professionals in society.

Any evaluation of the integrity of the medical profession must take into account the increasing role that medical technology plays in forcing upon patients what many consider to be unacceptable ways of dying. Howard Brody, *Assisted Death: A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384 (1992). Indeed, medical technology has exacerbated public fear of death. The public knows that doctors tend to overtreat terminally-ill patients. Steven H. Miles, *Physicians and Their Patients' Suicides*, 271 JAMA 1786 (1994); Kathleen M. Foley, *The Relationship of Pain and Symptom Management to Patient Requests for Physician-Assisted Suicide*, 6 J. Pain & Symptom Mgmt. 289, 290 (1991). Moreover, when modern medicine fails to provide a cure, some doctors withdraw, forcing a terminally-ill patient to

sustain much of the dying process on his or her own. *Id.*; *see also* Betty Rollin, *Last Wish* (Linden Press/Simon & Shuster 1985). In this context, the number of studies documenting inadequate palliative education and care by doctors and health care professionals is distressing but not surprising. *See, e.g.*, Alfred F. Conners *et al.*, *A Controlled Trial to Improve Care for Seriously Ill Hospitalized Patients*, 274 JAMA 1591 (1995). Thus, the integrity of the medical profession has been called into question because patients fear that physicians will either overtreat them with life-prolonging technology long after a return of meaningful function is impossible, or abandon them when they need control of symptoms or emotional support.

The public's concern over medical disregard for patient autonomy is also supported by empirical evidence. For example, physicians do not always involve their patients in discussions involving life-sustaining treatment. *See* Terri R. Fried *et al.*, *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 155 Archives Internal Med. 722, 723 (1993). The public's desire for increased self-determination in end-of-life medical decisions has been expressed through the successful ballot initiative for physician-assisted suicide in Oregon and similar referendums in California and Washington. The remarkable popularity of *Final Exit*, a manual for suicide, also testifies to the widespread public desire for certainty about how to end one's life reliably and painlessly. Block *et ano.*, 154 Archives Internal Med. at 2040.[7]

The origins of hospice care are a testament to the medical community's neglect, or inadequate treatment, of

[7] The availability of information concerning methods of committing suicide does not eliminate the need for legalized assisted-suicide. The hoarded pills and plastic-bag methods advocated in *Final Exit* hardly provide the dignified and certain ending sought by suffering patients. These methods are used in desperation, not dignity.

the terminally-ill. Hospice care developed out of a sense of frustration with the treatment of the dying, and as a reaction against the abuses of an impersonal high-technology approach to patients. Robert J. Miller, 20 *Hospice Care as an Alternative to Euthanasia*, 90 Law Med. & Health Care 127 (1992). Patient autonomy, personal choice and reclaiming control in one's final days of life have always been central to hospice philosophy. *See* Larry Beresford, *Hospice and the End of Life Debate*, Cal. Hospice Rep., Summer 1991, at 6. Thus, hospice professionals believe that a doctor's involvement in the dying process should be sufficiently flexible to account for all personal choices so that the individual need not experience a death characterized by abandonment, pain, impersonality and degradation. Brody, 327 New Eng. J. Med. at 1385.

Prohibiting physician-assisted suicide for suffering patients also undermines doctors' ability to provide the beneficence and comfort historically required of them. Quill *et al.*, 327 New Eng. J. Med. at 1380. The alleviation of suffering is as much a part of traditional medical care as is the prolongation of life. Helping a terminally-ill patient die at his or her request is at one end of the continuum of lifelong medical care when healing becomes impossible -- as it does in every life. Faye J. Girsh, *Physicians Aid in Dying: What Physicians Say, What Patients Say*, 157 W. J. Med. 188, 189 (1992); Block *et ano.*, 154 Archives Internal Med. at 2040.

Increasing the role of physicians, hospice and other medical professionals in the process of dying will enhance the public's respect for the medical profession on both an individual and institutional level. Brody, 327 New Eng. J. Med. at 1385 (1992); Franklin G. Miller *et al.*, 331 New Eng. J. Med. at 119 (1994). On an individual level, it will enable doctors and patients to talk about what the end will be like, thereby reinforcing the doctor-patient relationship. Because doctors often have intense

relationships with dying patients, a doctor's refusal to help a patient hasten death "may be experienced by the patient as an abandonment, a rejection or an expression of inappropriate paternalistic authority." Block *et ano.*, 154 Archives Internal Med. at 2045. In addition, open communication about what is causing the patient to make such a request will be fostered, and may ultimately lead to improved management of the distressing symptoms. Brody, 327 New Eng. J. Med. 1394. The doctor's role in enabling a patient to choose a good death is vital because patients lack the technical knowledge and skill, acting independently, to end their lives in a certain and humane manner. Those inclined to end their lives will not be prevented from doing so if physician-assisted suicide is illegal; they will instead opt for more grisly and less effective means.

On an institutional level, legalized assisted-suicide will enable physicians to consult with one another about a patient's request to hasten death, which also increases the likelihood that the patient's condition will be fully examined. Back, 275 JAMA at 925; Miller *et al.*, 331 New Eng. J. Med. at 121; Quill *et al.*, 327 New Eng. J. Med. at 1383. Moreover, legalization and regulation will put a clear responsibility on doctors to assess and treat depression and pain, commonly present and insufficiently treated in patients with terminal illnesses. Howard Brody, *Physician-Assisted Suicide Should Be Legalized*, 53 Archives Neurology 1182 (1996). Thus, the need for physician-assisted suicide would be reduced.

The States' argument that physician-assisted suicide undermines the public's respect for the medical profession lacks merit since physicians now engage in many legal practices to accelerate death for their patients. All hospice professionals, including the NHO, agree that physicians may terminate life-support systems, withhold all other forms of medical treatment, and may even administer drugs to sedate with full knowledge of their

"double effect." NHO *Amicus* Br. at 3; Miller *et al.*, 331 New Eng. J. Med. 119. Physicians who prescribe drugs to hasten death will not be looked upon as "killers" any more than physicians who now take actions, such as disconnecting respirators, that result in the deaths of their patients. *See Quill*, 80 F.3d at 730; *Cruzan*, 497 U.S. at 296-98 (Scalia, J., concurring) (no distinction between action and inaction when both result in death). To deny dying patients the right to choose self-administered prescription drugs as an alternative to assured anguish and degradation, and then to hide this prohibition under the veil of protectionism, is offensive not only to individual autonomy, but also to the will of the American populace, who, as surveys indicate (*see supra*, p. 9) want this choice to be legal.

4. The Availability of Physician-Assisted Suicide Protects The Interests Of Family Members And Loved Ones. -- The states also assert an interest in protecting the family and friends of terminally-ill individuals. The Coalition submits that affirming the lower courts' decisions furthers that interest by ensuring that family members and friends will not be forced to choose between witnessing a loved one suffer a slow and agonizing death, or acting to assist him or her to end the suffering.

The Coalition knows that the family and friends of terminally-ill individuals experience painful feelings of helplessness and guilt at impotently watching a loved one's prolonged suffering. See, e.g., Betty Rollin, *Last Wish*. Thus, these people often empathize with their loved one's desire to hasten death.

While it is impossible to account for the number of suicides by the terminally-ill that have involved the assistance of family members or friends, there is evidence that the practice exists:

> Family members, family physicians, friends, and even freelance euthanasists . . . are now assisting in

> suicides with no more guidance than their own limited personal experiences and rules. No survey, no poll, no investigation, no educated guesses will ever yield knowledge of the number of people who have died by overdoses, plastic bags, self-inflicted gunshot wounds, or physician-administered lethal drugs -- when they should instead simply have had good counseling and better medical treatment of their pain, shortness of breath, or depression.

Shavelson, *A Chosen Death* at 103. *See also* Miller *et al.*, 331 New Eng. J. Med. 119. Moreover, such attempts frequently fail -- with tragic consequences for the terminally-ill individual. *See, e.g.*, Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. Times, June 14, 1994, at C12 (describing academic study which "shows that in the absence of regulation and medical supervision, [assisted-suicide] is occurring in horrific circumstances, like back-street abortions."); Kolata, N.Y. Times, June 14, 1994 C1 (reporting instances of unsuccessful assisted suicides including story of Illinois man who tried to smother terminally-ill friend with a pillow but instead asphyxiated him just enough to destroy most of his brain's functions).

In addition, prohibiting physician-assisted suicide adversely affects the bereavement process of family members and friends of a terminally-ill patient who chooses to hasten death. Patients seeking to protect their loved ones from potential criminal prosecution are likely to plan and commit suicide without informing them. The secrecy surrounding such a death instills confusion, guilt and uncertainty in the survivors which hampers their grieving process. In addition, where the loved one provides assistance in hastening death, the secrecy is compounded since he or she is unable to talk about the death for fear of adverse legal consequences.

One of the most consistent findings in the clinical bereavement literature is the importance of social support for the survivors. When the mourner perceives that

support is not available or that the loss is not socially acceptable or acknowledged, there is an increased risk for complicated mourning. Therese A. Rando, *Treatment of Complicated Mourning*, 495 (Research Press, Champaign, IL 1993). Confiding in others plays a central role in the coping process; behavioral inhibition places cumulative stress on the body and increases the long-term possibility of stress-related disease and psychological damage. J.W. Pennebaker, R.C. O'Herron, *Confiding in Others and Illness Rates Among Spouses of Suicide and Accidental-death Victims*, 93 J. of Abnormal Psych., 473-476 (1984).

Legalization of physician-assisted suicide would provide an environment in which the dying person is not forced to act in secret and one in which family members could be present at the assisted death and discuss it in an open and healthy fashion. Additionally, legalization would enable family members and friends, who wish to honor their loved one's request for help to end his or her intractable suffering to obtain the assistance of experienced physicians. This is clearly preferable to exposing family members and friends to the legal, medical and psychological risks presently associated with assisting a loved one to die.

CONCLUSION

For the foregoing reasons, and for those set forth in the Respondents' briefs, the judgments below should be affirmed.

Respectfully submitted,

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APPENDIX

The Coalition's members are representative of every facet of the hospice caregiving team. These palliative care specialists practice in hospices and hospitals throughout the country; serve on ethics committees and policymaking boards; instruct medical students; and are responsible for the operation of individual hospices, hospice systems, specialized clinics, and family medical practices.

The Coalition's members are: Rev. Diane Bagues, hospice chaplain; Robert Bendiksen, Ph. D., professor, University of Wisconsin-LaCrosse, member of Gunderron Lutheran IRB/Human Subjects Subcommittee; Zail Berry, M.D., former medical director of Washington, D.C. Home and Hospice; Robert Brody, M.D., chief, Pain Consultation Clinic and chair, Ethics Committee, San Francisco General Hospital and clinical professor of Medicine, University of California, San Francisco; Michael J. Cassidy, M.D., medical director Hospice Visiting Nurse Association and Hospice of Northern California; Joanna Cooper, M.D., clinician, East Bay Neurology, Berkeley, California; William Curtis, M.D., radiologist, member of Hospice Ethics Committee, member of Boulder County and Colorado Medical Society, emeritus member of American Medical Association; Susan Edenborough, director, Crossroads Home and Hospice, San Francisco; Jonathan Gavrin, M.D., anesthesiologist, internist and palliative care specialist, and a member of the faculty at University of Washington and Fred Hutchinson Cancer Research Center; David Hibbard, M.D., family practitioner, Hospice Ethics Committee member; Sarah Hogenauer, R.N., M.S., coordinator, Hospice Care Network, Westbury, New York; Constance Holden, R.N., M.S.N., clinical nurse specialist, executive director of

Hospice of Boulder County, Colorado, a member of the NHO Ethics Committee and the Colorado Governor's Commission on Life and the Law; Rev. Edward Holland, United Methodist Minster and hospice chaplain; Gary Johanson, M.D., a member of the American Academy of Hospice and Palliative Medicine Ethics Committee; Frank P. Lamendola, R.N., Ph. D. candidate, University of Minnesota, former hospice nurse manager; Eric Loewy, M.D., professor of Medicine, University of California, Davis; Fred Marcus, M.D., oncologist and palliative care specialist, attending physician, Stanford University Hospital, Internal Medicine and Oncology; Larry D. Miller, R.N., former hospice director; Linda Norlander, R.N., B.S.N., hospice administrator, member of Minnesota Hospice Organization Legislative Committee; Ben A. Rich, J.D., Ph. D., assistant professor and assistant director, Program in Health Care Ethics, Humanities and Law, University of Colorado Health Center, and a member of the Ethics Committee of the Hospice of Boulder County, Colorado; Patricia Carson Sussman, director of Hospice for Visiting Nurses' Association and Hospice of Northern California; John Stansell, M.D., medical director of San Francisco General Hospital AIDS Clinic; and Phyllis Taylor, R.N., hospice nurse and educator.

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Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York, *et al.*,

Petitioners,

—v.—

TIMOTHY E. QUILL, M.D., *et al.*,

Respondents.

STATE OF WASHINGTON, *et al.*,

Petitioners,

—v.—

HAROLD GLUCKSBERG, M.D., *et al.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SECOND CIRCUIT AND NINTH CIRCUIT

BRIEF *AMICI CURIAE* OF THE AMERICAN MEDICAL STUDENT ASSOCIATION AND A COALITION OF DISTINGUISHED MEDICAL PROFESSIONALS IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

Page

INTEREST OF *AMICI CURIAE* 1

SUMMARY OF ARGUMENT 2

ARGUMENT 3

I. THE CLINICAL REALITIES OF TERMINALLY ILL PATIENTS DO NOT JUSTIFY THE LEGAL DISTINCTIONS URGED BY PETITIONERS. 3

A. Medical Realities Do Not Support A Bright-Line Legal Distinction Between Refusal Of Life Support And Assisted Suicide. 4

1. Terminally Ill Patients And The Physicians Who Aid Them In Dying Intend To Give The Patient Control Of The Process Of Dying. 5

2. A Physician Who Withdraws Life Support Actively Causes The Patient's Death 7

3. The Medical Environment In Which Terminally Ill Patients Typically Spend Their Final Days Necessarily Affects The Time And Manner Of Their Death. 8

B. Terminally Ill Patients Should Not Be Forced To Choose Between Enduring Severe Pain And Surrendering Their Constitutional Right To Avoid Unwanted And Dehumanizing Medical Treatment . . 9

II. PHYSICIAN-ASSISTED SUICIDE IS FULLY CONSISTENT WITH PETITIONERS' INTEREST IN PROTECTING THE ETHICAL INTEGRITY OF THE MEDICAL PROFESSION. 11

A. The Prohibition Of Physician-Assisted Suicide Is Inconsistent With The Medical Profession's Obligation To Respect Patient Autonomy And To Comfort Rather Than Abandon The Dying. 12

B. The State's Interest In Preventing Doctors From Intentionally Harming Patients Does Not Justify A General Prohibition Of Physician-Assisted Suicide. 14

III. REGULATION OF PHYSICIAN-ASSISTED SUICIDE IS FEASIBLE AND WOULD BETTER SERVE PETITIONERS' INTEREST IN PREVENTING POTENTIAL ABUSE THAN THE CURRENT SECRET PRACTICE. 17

A. State Regulation Of End-of-Life Decisions Is Already Well-Established. 19

B. Comprehensive Regulations For Physician-Assisted Suicide Have Already Been Promulgated 22

C. Regulation Of Physician-Assisted Suicide Is Just As Feasible As Regulation Of Other End-of-Life Decisions 25

1. Terminal Illness 25

2. Informed Consent 27

3. Voluntariness 28

4. Competence Or Capacity 28

CONCLUSION 30

APPENDICES

APPENDIX A (Individual Medical Professional *Amici*) ... A-1

APPENDIX B (*A Model State Act to Authorize and Regulate Physician-Assisted Suicide*) B-1

APPENDIX C (*BANEC-Generated Guidelines for Comprehensive Care of the Terminally Ill*) C-1

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Page

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INTEREST OF *AMICI CURIAE*

The American Medical Student Association ("AMSA") and an ad hoc coalition of distinguished medical professionals respectfully submit this brief as *amici curiae* in support of Respondents. We file this brief with the consent of all parties.[1]

Founded in 1950, AMSA is an independent, non-profit organization representing nearly 30,000 physicians-in-training from medical schools across the country. AMSA, thus, represents the future of medicine in the United States.

The individual *amici*[2] are licensed medical professionals and educators with both clinical and academic expertise in the end-of-life issues confronting terminally ill patients. Some of us have written papers and articles on the clinical and bioethical aspects of end-of-life medical decisions; others have participated in the writing of guidelines and model statutes for the regulation of physician-assisted suicide. As a result of our experience, we are among the growing number of medical professionals who believe that, in certain limited and carefully-regulated circumstances, physician-assisted suicide should be a lawful option available to competent, terminally ill patients.[3]

---

1. Copies of letters of consent are being filed with the Court at the same time as the filing of this brief.

2. See Appendix A for a fuller description of each of the individual medical professional *amici*.

3. *See, e.g.*, David Orentlicher, *The Legalization of Physician-Assisted Suicide*, 335 New Eng. J. Med. 663, 666 (1996) ("Surveys of physicians demonstrate . . . majority support" for physician-assisted suicide.) ("Orentlicher, *Legalization*") (citations omitted); Jerald G. Bachman et al., *Attitudes of Michigan Physicians and the Public Toward Legalizing Physician-Assisted Suicide and Voluntary Euthanasia*, 334 New Eng. J. Med. 303, 306-07 (1996) (56% of Michigan physicians support legalization of physician-assisted suicide); Ezekiel J. Emanuel et al., *Euthanasia and Physician-Assisted Suicide: Attitudes and Experiences of Oncology Patients, Oncologists, and the Public*, 347 Lancet 1805, 1807 (1996) ("Emanuel, *Oncology Patients*") (45.5% of oncologists agree with physician-assisted suicide for patients in unremitting pain); Jonathan S. Cohen, *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians In Washington State*, 331 New Eng. J. Med. 89, 89 (1994)

We recognize that, for most patients, palliative care options exist and a physician can adequately ease a patient's suffering even when there is no cure for the patient's underlying condition. For this reason, we strongly support hospice and other comprehensive palliative care initiatives as the standard of care for the dying. When appropriate palliative care is adequate to relieve the patient's pain and suffering, we do not believe that physician-assisted suicide is an advisable option.

However, we also recognize that even the highest quality palliative care will not always adequately ease a patient's suffering. In such exceptional circumstances, mentally competent terminally ill patients should have the option of a safe, legal and state-regulated means of hastening death with the assistance of a physician.

SUMMARY OF ARGUMENT

Terminally ill patients who are competent and make a voluntary choice to hasten their death with the assistance of their physician should have the same right to control the time and manner of death as patients who refuse life-sustaining treatment. There is no clinical basis for distinguishing these two classes of patients based on purported categorical differences in either (*i*) the intent of the patient or the physician or (*ii*) the extent to which the active intervention of the physician affects the time and manner of the patient's death. Furthermore, criminal prohibition of assisted suicide compels many terminally ill patients to surrender their right to refuse unwanted and degrading medical treatment in order to relieve otherwise untreatable pain.

Petitioners' interests in protecting the ethical integrity of the medical profession and in limiting physician-assisted suicide to

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(54% of Washington doctors believe physician-assisted suicide should be legal in some situations).

competent, terminally ill patients who voluntarily choose to hasten their deaths also fail to support their general prohibition of the practice. Preventing physicians from assisting such patients is inconsistent with important principles of medical ethics because it may force doctors to abandon their patients, and to ignore their requests for information, assistance, and comfort, at a time when the patient is most in need because he or she is confronting both severe suffering and imminent death. Nor is it necessary to force competent patients to endure a prolonged, painful, and pointless process of dying in order to ensure that the practice of physician-assisted suicide is appropriately regulated. Detailed regulatory schemes have already been promulgated which involve the same types of medical judgments and legal protections that have been successfully used in other, long-established end-of-life decisions.

ARGUMENT

I. THE CLINICAL REALITIES OF TERMINALLY ILL PATIENTS DO NOT JUSTIFY THE LEGAL DISTINCTIONS URGED BY PETITIONERS.

Petitioners contend that it is constitutionally permissible for them to distinguish between the withdrawal or refusal of life support and physician-assisted suicide. Their justifications for such a distinction, however, simply ignore the clinical realities of terminally ill patients. Furthermore, in many instances, the artificial distinctions Petitioners seek to draw merely compel patients who are not on life support to surrender their right to refuse dehumanizing medical treatment in order to escape prolonged and intolerable suffering.

A. Medical Realities Do Not Support A Bright-Line Legal Distinction Between Refusal Of Life Support And Assisted Suicide.

The patients who brought these cases sought the same general right that this Court recognized in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990): to exercise the deeply personal choice to hasten the end of their lives as the only alternative to a painful and degrading process of dying. In denying this right to patients who seek the aid of their doctors in hastening their death, Petitioners rely on three purported categorical distinctions between such patients and those who refuse life-sustaining measures:

- whether the physician or the patient intend the patient's death or merely know that it is a foreseeable consequence of the physician's efforts to relieve suffering;
- whether the physician acts to hasten death or merely fails to take actions to prevent or delay death; and
- whether the time and manner of the patient's death is caused by medical intervention or is the "natural" result of an underlying illness.

These purportedly dispositive differences in intent, action, and causation, however, simply do not withstand scrutiny in light of the medical and clinical realities of terminally ill patients and their treatment. *See generally* Orentlicher, *Legalization* at 663 (explaining why categorical distinction between refusal of treatment and assisted suicide is no longer appropriate in light of changes in medical treatment of terminally ill patients).

1. Terminally Ill Patients And The Physicians Who Aid Them In Dying Intend To Give The Patient Control Of The Process Of Dying.

Petitioners contend that the intent of patients and physicians who participate in physician-assisted suicide is necessarily different from that of the patient and physician who refuse, withhold, or withdraw life-sustaining measures. In the case of physician-assisted suicide, the specific intent purportedly must be the death of the patient, *see Vacco* Pet'r Br. at 15-16; *Glucksberg* Pet'r Br. at 44, while where life-sustaining treatment is being refused, death is merely an unintended, albeit often inevitable, consequence of a desire to relieve the patient's suffering and indignity, *see Vacco* at 13-14. There is simply no basis, however, for presumptively ascribing such different intentions and purposes to patients and physicians in these two circumstances.

Such a simplistic and arbitrary account of the intentions of those who participate in physician-assisted suicide trivializes the inherently complex and multiple motivations involved in any end-of-life decision. *See* Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039 (1993) ("Quill, *Ambiguity*"). Thus, in requesting and prescribing a potentially lethal dosage of medication, the immediate goal of both patient and physician may be nothing more than to give the patient "a greater sense of control" over the process of dying and both may hope that the patient is never forced to take this final step in order to relieve their suffering. N.Y. Task Force On Life and Law, *When Death Is Sought: Assisted Suicide and Euthanasia in the Medical Context*, 83 (1994) ("N.Y. Task Force Report"), *see also* Quill, *Ambiguity*; Timothy E. Quill, *Doctor, I Want to Die*, 7 JAMA 870, 872 (1993).

Indeed, in many cases, patients who have been prescribed

a lethal dosage never take the medication.[4] Rather, the medication serves its intended purpose by reassuring the patient that their terminal condition need not lead to dependency or indignity. *See, e.g.*, Susan D. Block, *Patient Requests to Hasten Death: Evaluation and Management in Terminal Care*, 154 Archives Internal Med. 2039, 2045 (1994) ("Block, *Patient Requests*") ("[A]cceptance of the patient's wish for hastened death . . . may paradoxically allow the patient enough control and confidence in his or her ability to manage the future so that the option of suicide does not have to be exercised."). For some patients, this sense that they retain control of their lives provides sufficient comfort to make their final days bearable. *E.g.*, Kingsley Decl. ¶¶ 11-12 (*Vacco* J.A. 99, 101-02); Grossman Decl. ¶¶ 15 (*Vacco* J.A. 84, 87); *see also* N.Y. Task Force Report at 92 ("The most frightening aspect of death for many is not physical pain, but the prospect of losing control and independence and of dying in an undignified, un[a]esthetic, absurd, and existentially unacceptable condition.").

Even where the patient chooses to hasten her death, her ultimate goal is no different from that Petitioners ascribe to those who reject life sustaining treatment: to avoid a prolonged and dehumanizing process of dying. No less than those on life support, such patients seek to hasten death "because the quality of life during the time remaining . . . ha[s] been terribly diminished" and their life "has been physically destroyed and its quality, dignity and purpose gone." *See Bouvia v. Superior Court*, 225 Cal. Rptr. 297, 304-05 (Cal. Ct. App. 1986) (describing patient's reasons for withdrawal of life support). Regardless of the means by which death is hastened, the intent and purpose of both categories of terminally ill patients are essentially the same.

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4. *See, e.g.*, Anthony L. Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996) ("Back, *Physician-Assisted Suicide in Washington*"); Andrew Solomon, *A Death of One's Own*, New Yorker, 54, 58 (May 22, 1995) ("Solomon, *Death of One's Own*").

2. A Physician Who Withdraws Life Support Actively Causes The Patient's Death.

Equally meritless is Petitioners' attempt to distinguish assisted suicide from withdrawal of life support by arguing that, in the latter case, the physician takes no affirmative action that causes the patient's death. *See Vacco* Pet'r Br. at 17; *Glucksberg* Pet'r Br. at 30. This contention simply ignores the clinical reality of life-sustaining technology. For example, to disconnect a respirator, a physician or nurse must take each of the following steps:

1. turn off the respirator;
2. disconnect the machine from the tube that goes to the patient's lungs;
3. remove the tube from the patient's lungs;
4. administer morphine or barbiturates to ease the patient's sense of suffocation; and
5. monitor medication levels to ensure that symptoms of severe air hunger do not arise.

See Quill Supplemental Decl. ¶ 5 (*Vacco* J.A. 116-117) ("Quill Supp. Dec.").[5]

Furthermore, it is clear that when a patient is subject to on-going life-sustaining treatment, the withdrawal of that treatment will be a cause of the patient's death. For example, when a physician stops a respirator, death results because breathing stopped, but the cause of death is also the physician's act in halting the respirator. *See McKay v. Bergstedt*, 801 P.2d 617, 634 (Nev.

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5. Furthermore, when a patient refuses or requests withdrawal of life support, the physician may dispense drugs that ease the patient's suffering, but also hasten death. For example, when a doctor stops a patient's food and hydration, the ensuing bodily reaction requires the physician to treat these symptoms with sedatives that may hasten the patient's death. Quill Supp. Dec. ¶ 6 (*Vacco* J.A. 117-18).

1990) (Springer, J., dissenting). Similarly, when a physician halts food and hydration, death occurs because the patient is unable to eat or drink, but the physician is causally responsible for the death as a result of issuing the order to stop providing food and hydration. *See Brophy v. New Eng. Sinai Hosp. Inc.*, 497 N.E.2d 626, 631 (Mass. 1986) (Nolan, J. dissenting) (explaining that removal of feeding tube leads to death by dehydration and starvation). There can be no question that if a physician performed either of these actions without the patient's consent, she would be legally responsible for causing the patient's death just as surely as if she had shot her patient. *See* Orentlicher, *Legalization* at 663.

3. The Medical Environment In Which Terminally Ill Patients Typically Spend Their Final Days Necessarily Affects The Time And Manner Of Their Death.

Petitioners finally argue that refusal or withdrawal of life-sustaining measures and physician-assisted suicide are materially different because, in one case, the time and manner of death are the result of "natural" processes, while, in the other, they are affected by the action of physicians and other medical professionals. *See Vacco* Pet'r Br. at 17-18; *Glucksberg* Pet'r Br. at 12, 30, 38. This distinction also ignores the clinical reality of terminally ill patients.

It is a fundamental fact of contemporary medicine that death rarely occurs "naturally" and apart from significant medical intervention. Indeed, in 1992 nearly 80% of all deaths in this country occurred in hospitals. *See* Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 Cal. L. Rev. 857, 858 (1992). In such a setting, both the time and manner of a patient's death are necessarily often the result of a series of conscious decisions and affirmative actions by the patient and her physicians.

In particular, the extensive medical treatment received by

most terminally ill patients will often have collateral consequences that affect both the timing and the manner of the patient's ultimate death in a way that makes it meaningless to describe death as occurring "naturally." *See, e.g.*, Froom Decl. ¶ 11 (*Vacco* J.A. 125, 126) ("With advancing medical technology, many patients are subject to active and ineffective therapeutic efforts by their physicians, even when an early terminal outcome is not in doubt.").[6] For example, a cancer patient's chemotherapy may temporarily treat the illness, but it also may damage vital organs in the process and thereby affect when and how the patient may die. *See Clinical Oncology*, 789-813 (Martin D. Abeloff et al. eds 1995) (describing pulmonary and cardiac complications resulting from cancer therapy). Because the precise circumstances of death for most terminally ill patients will be determined in part by the effect of such medical interventions, the death of such patients cannot fairly be described as "natural."

B. Terminally Ill Patients Should Not Be Forced To Choose Between Enduring Severe Pain And Surrendering Their Constitutional Right To Avoid Unwanted And Dehumanizing Medical Treatment.

Although Petitioners and their *amici* suggest that adequate palliative care options are virtually always available for terminally

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6. The affidavits of the patients who brought the *Vacco* action graphically illustrate some of the effects of such treatments on terminally ill patients. *See, e.g.*, Barth Decl. ¶¶ 3-4, 9-10 (*Vacco* J.A. 96, 97-98) (describing adverse side effects of treatments for disease); Doe Decl. ¶ 10 (*Vacco* J.A. 106, 107) (describing scarring inside throat and neck from surgery and radioactive iodine treatment; burning and swelling in neck and nausea from radiation therapy; pain, nausea, and vomiting from tube feeding); Kingsley Decl. ¶ 8 (*Vacco* J.A. 101) (describing "cramping," "gas with bloating" and "total loss of appetite" from medication to prevent infection; administration of medication through Hickman tube connected to chest artery prohibited showering and made simple routine functions burdensome).

ill patients, *see, e.g., Glucksberg* Pet'r Br. at 18; American Medical Association ("AMA") *Vacco* Br. at 6-7, they ignore the cruel and dehumanizing nature of the "care" that may be required and the extent to which it may compel the patient to surrender his or her right to refuse unwanted and degrading medical treatment. In some instances, palliative care for terminally ill patients also impairs those patients' most basic bodily functions.[7] "Adequate" palliative care may also require extended periods of sedation to the point of permanent or temporary unconsciousness. *See* AMA *Vacco* Br. at 6 ("For a very few patients, however, sedation to a sleep-like state may be necessary in the last days or *weeks of life* to prevent the patient from experiencing severe pain.") (emphasis added).[8] Indeed in some cases, patients may be sedated to the point where they require life support and then are "allowed to die" by withholding the necessary life-sustaining treatment.[9] This last practice

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7. *See, e.g.* Kingsley Decl., ¶ 8 (*Vacco* J.A. 101); Grossman Decl. ¶¶ 13-14 (*Vacco* J.A. 86-87).

8. *See also* Robert E. Enck, *The Medical Care of Terminally Ill Patients* 166-172 (1994) (summarizing recent studies on degree and frequency of sedation of terminally ill patients); Paul Rousseau, *Terminal Sedation in the Care of Dying Patients*, 156 Archives of Internal Med. 1785, 1786 (1996) ("some [terminally ill] patients may require profound sedation"); Nathan I. Cherny et al., *Sedation in the Management of Refractory Symptoms: Guidelines for Evaluation and Treatment*, 10 J. of Palliative Care 31, 36 (1994) (adequate palliative care for the terminally ill may require sedation involving permanent or temporary "total loss of interactional function"; attempts to adjust dosages of sedatives "to reestablish lucidity after an agreed interval or for pre-planned family interactions" risk "possibility that lucidity may not be promptly restored or that death may ensue as doses are again escalated"). In addition, there can be no certainty that a patient who has been sedated to unconsciousness will, in fact, cease to experience pain. *See* Michael P. McQuillen, *Can People who are Unconscious or in the "Vegetative State" Perceive Pain?*, 6 Issues in L. & Med. 373 (1991).

9. *See* Robert J. Hall, *Final Act: Sorting Out the Ethics of Physician-Assisted Suicide*, 54 Humanist 10 (Nov./Dec. 1994) ("Hall, *Final Act*") ("The most recent answer to such problems, which may well become standard practice, is to sedate these patients into complete unconsciousness and to withhold nutrition and hydration until they die."); Timothy E. Quill et al.,

illustrates the utter artificiality of the line Petitioners seek to draw.

Terminally ill patients may refuse such palliative care based on their right to refuse unwanted medical treatment. *E.g., Cruzan*, 497 U.S. at 279; *Vacco* Pet'r Br. at 10. But the price of exercising this right is to remain conscious and to suffer both intolerable pain and an awareness of all of the indignities resulting from the ravages of the illness and its treatment. Doe Decl. ¶ 9 (*Vacco* J.A. 107) ("[I]t is not possible for me to reduce my pain to an acceptable level of comfort and to retain an alert state."); Klagsbrun Decl. ¶ 16 (*Vacco* J.A. 71) ("Pain management at the end stage of cancer often requires the patient to choose between enduring unrelenting pain or sacrificing an alert mental state to the high dose of drugs adequate to alleviate pain."). In short, for some terminally ill patients, the choice Petitioners offer between palliative care or extreme pain and suffering is both cruel and meaningless.

II. PHYSICIAN-ASSISTED SUICIDE IS FULLY CONSISTENT WITH PETITIONERS' INTEREST IN PROTECTING THE ETHICAL INTEGRITY OF THE MEDICAL PROFESSION.

Petitioners' contention that they can require terminally ill patients to endure unnecessary and intolerable suffering in order to vindicate their interest in maintaining the integrity and ethical standards of the medical profession, *see Vacco* Pet'r Br. at 14-15, 31-32, is equally misplaced. As even those who support Petitioners' position, such as the AMA, acknowledge, established principles of medical ethics fully support a physician providing

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Physician-Assisted Death: A Comparison of Terminal Sedation, Assisted Suicide, and Voluntary Active Euthanasia, (manuscript at 8, on file with author) ("the suffering patient is put into an iatrogenic coma, usually using barbiturates or benzodiazepines, and then dies of dehydration, starvation, or some other intervening complication, as all life-sustaining interventions are withheld").

medication that will hasten a patient's death where the patient has voluntarily chosen this outcome as the only means of relieving severe suffering. Petitioners and the AMA argue, however, that the same conduct becomes unethical where a physician frankly acknowledges, or otherwise reveals, that her aim is to assist the patient in controlling the time and manner of their death. This distinction, however, makes no sense as a matter of professional ethics or public policy. Indeed, the criminal prohibition of physician-assisted suicide prevents doctors from fulfilling important ethical obligations to dying patients and encourages furtive practices that are akin to voluntary euthanasia and have a greater potential for abuse.

A. The Prohibition Of Physician-Assisted Suicide Is Inconsistent With The Medical Profession's Obligation To Respect Patient Autonomy And To Comfort Rather Than Abandon The Dying.

Petitioners' criminal prohibition of physician-assisted suicide conflicts with the medical profession's well-established ethical obligations to respect patient autonomy and to continue to attend to and comfort their patients, even when they may have an incurable illness. Indeed, it forces doctors to choose between violating the law and abandoning patients at a time when they are most in need and have expressed a desire to hasten their death as the only way of avoiding intolerable and untreatable suffering.

A traditional role of the physician, and a central goal of medicine, is to help people die with meaning, comfort and dignity. *See* AMA Council on Ethical and Judicial Affairs, *Code of Medical Ethics*, Opinion 2.20, at 40 (1996) ("*AMA Code*") ("Physicians have an obligation to relieve pain and suffering and to promote the

dignity and autonomy of dying patients in their care."). [10] In addition, as the AMA Council on Ethical and Judicial Affairs acknowledges in its opinion on physician-assisted suicide, medical ethics mandate that "[p]atients should not be abandoned once it is determined that cure is impossible." *AMA Code*, Opinion 2.211, at 56. [11] Indeed, "[t]o allow a [terminally ill] patient to experience unbearable pain or suffering is unethical medical practice." Sidney H. Wanzer et al., *The Physician's Responsibility Toward Hopelessly Ill Patients*, 320 New Eng. J. Med. 844, 847 (1989).

The principle of patient autonomy is equally central to medical ethics and to defining the physician's role in end-of-life decisions. As the AMA Council on Ethical and Judicial Affairs stated in its opinion on withholding or withdrawing life-sustaining medical treatment, "[t]he social commitment of the physician is to sustain life *and* relieve suffering. *Where the performance of one duty conflicts with the other, the preferences of the patient should prevail.*" *AMA Code*, Opinion 2.20, at 39 (emphasis added); *see also id.* at 40 ("Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying

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10. *See also* Medical Society of the State of New York, *Principles of Professional Conduct*, ch. 1, § 1 (1995-96) ("The prime object of the medical profession is to render competent medical service with compassion and respect for human dignity."); Eric J. Cassel, *The Nature of Suffering and the Goals of Medicine*, 306 New Eng. J. Med. 639, 639 (1982) ("The obligation of physicians to relieve human suffering stretches back into antiquity."); Hall, *Final Act*; John R. Peteet, *Treating Patients Who Request Assisted Suicide -- A Closer Look at the Physician's Role*, 3 Archives Fam. Med. 723, 726 (1994).

11. *See also AMA Code*, Opinion 8.11, at 123 ("Once having undertaken a case, the physician should not neglect the patient."); Howard Brody, *Assisted Death -- A Compassionate Response to a Medical Failure*, 327 New Eng. J. Med. 1384, 1385 (1992) ("[W]alking away, denying that medicine can do anything to help in the patients's plight, is an immoral abrogation of medical power, especially in cases in which the prior exercise of the medical craft has extended the patient's life and resulted in the complications that have brought the patient to the present state of suffering."); Timothy E. Quill & Christine K. Cassel, *Nonabandonment: A Central Obligation for Physicians*, 122 Annals Internal Med. 368, 368 (1995).

patients in their care.").[12] Each patient must be allowed to make life-and-death decisions within the broader context of her own beliefs concerning the purpose and value of her existence. After all, "health and life extension are ultimately of value in the service of the broader overall well-being of the patient. They are of value in so far as they facilitate the patient's pursuit of his or her overall plan of life; the aims, goals and values important to the particular patient." Dan W. Brock, *Death and Dying*, in *Medical Ethics* 329, 334 (Robert M. Veatch ed. 1989). Thus, medical professionals should respect a patient's decision to hasten her death when the patient's remaining life offers nothing more than an intolerable and undignified process of dying. *See AMA Code*, Opinion 2.211, at 56 ("It is understandable, though tragic, that some patients in extreme duress -- such as those suffering from a terminal, painful, debilitating illness -- may come to decide that death is preferable to life.").

B. A State's Interest In Preventing Doctors From Intentionally Harming Patients Does Not Justify A General Prohibition Of Physician-Assisted Suicide.

Petitioners and their supporting *amici* contend that their interest in maintaining the integrity of the medical profession justifies a general prohibition against intentionally hastening the death of a patient even where precisely the same conduct would be lawful if done solely to relieve the patient's suffering. This distinction between instances where a doctor intentionally assists a patient in ending her life and so-called "double effect" cases in

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12. AMA Council on Ethical and Judicial Affairs, *Decisions Near the End of Life*, 267 JAMA 2229, 2231 (1992) ("[The AMA recognizes that] a competent patient must be the one who decides whether the relief of pain and suffering is worth the danger of hastening death. The principle of respect for patient autonomy and self-determination requires that patients decide about such treatment.").

which death is foreseeable, or even certain, but purportedly not intended is not supported by either medical ethics, legitimate policy considerations, or common sense.[13]

Petitioners argue that the principle that doctors should not intentionally harm their patients trumps all the other ethical considerations that support physician-assisted suicide.[14] This takes an unreasonably narrow view of what may constitute harm for a patient suffering irremediable and severe pain and confronting an imminent and unavoidable death. For such a patient, death may constitute not harm but the only available relief; the true harm may lie in being compelled either to continue unnecessary suffering or

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13. The AMA formally explained its position on the "double effect" doctrine in an opinion by its Council on Ethical and Judicial Affair which stated that "pain medications may be [ethically and legally] administered in whatever dose necessary to relieve the patient's suffering, even if the medication has the side effect of . . . causing death through respiratory depression." AMA Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide* (Dec. 1993), *reprinted in* 10 Issues L. & Med. 91, 95 (1994); *see also AMA Code*, Opinion 2.20, at 40.

14. Although the AMA relies on the Hippocratic Oath for this proposition, *see* AMA *Vacco* Br. at 5, it is clear that the Oath does not represent the best or final word on modern medical ethics and controversies. Even at its inception, the Oath was not accepted by all ancient physicians. *See Roe v. Wade*, 410 U.S. 113, 131-32 (1973); *Encyclopedia of Bioethics*, Appendix at 2632 (Warren T. Reich ed., rev. ed. 1995). In fact, the strict provisions of the Oath forbid many medical procedures which are widely accepted today as ethical or legal, including abortion, "double effect" pain medication, and even surgery in any form. *See Encyclopedia of Bioethics*, Appendix at 2632 ("I will neither give a deadly drug to anybody if asked for it, nor will I make a suggestion to this effect. Similarly I will not give to a woman an abortive remedy. . . . I will not use the knife, . . . but will withdraw in favor of such men as are engaged in this work.") (quoting Hippocratic Oath). For this reason, it has often been "retranslated" or modified. *See, e.g.*, Noah Adams, *Doctor Examines Evolution of Hippocratic Oath*, National Public Radio transcript #2199-4, April 30, 1996 (noting that at Johns Hopkins Medical School, the oath used at graduation ceremonies has been altered to "I will give no drug or perform no operation without a justifiable purpose."). Thus, the Hippocratic Oath should have no greater weight here than it did in determining whether women have a constitutional right to an abortion. *See Roe*, 410 U.S. at 131-32.

to end one's life in a lonely and violent manner.[15]

Furthermore, by sanctioning the practice of directly administering medications that will foreseeably cause a patient's death, the "double effect" doctrine allows physicians to engage in practices that are far closer to voluntary, or even involuntary, active euthanasia than physician-assisted suicide. *See* Robert D. Truog et al., *Barbiturates in the Care of the Terminally Ill*, 327 N. Eng. J. of Med. 1678 (1992) (describing practice of administering barbiturates to relieve pain of terminally ill patients with unavoidable side effect of hastening death).

Nor is there any basis for believing that an open and legal practice of physician-assisted suicide would undermine patients' trust in their doctors because patients will come to view their doctors as killers. *See* AMA *Vacco* Br. at 21. First, it is difficult to see how more openness in the doctor-patient relationship will lead to less trust. To the contrary, imposing criminal liability only where there is evidence of the physician's intent to hasten death has

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15. Examples of such suicides are numerous: patients have jumped from bridges, withheld their own insulin to die of insulin shock, shot themselves in the head, suffocated themselves with plastic bags, and taken overdoses of prescription or over-the-counter drugs. *See, e.g., Compassion in Dying v. Washington*, 79 F.3d 790, 834-35 & n. 135 (9th Cir.), *cert. granted*, 117 S. Ct. 39 (1996); *Quill v. Vacco*, 80 F.3d 716, 724 (2d Cir.), *cert. granted*, 117 S. Ct. 36 (1996); Solomon, *Death of One's Own*, at 57. Moreover, a patient who seeks to commit unassisted suicide (or suicide assisted by a layperson) is most likely unaware of what drugs or dosage they must use. Physical inability or miscalculation can lead to an even more drawn-out, painful and undignified death. *See, e.g.*, Russel D. Ogden, *Euthanasia: Assisted Suicide & AIDS* (1994) (approximately half of the layperson-assisted suicides were unsuccessful and increased the patient's suffering, rather than mitigating it); *Compassion in Dying*, 79 F.3d at 836 n.135; *Quill*, 80 F.3d at 721 ("Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts."). In addition, the negative effects of a violent unassisted suicide on the patient's family members extends the tragedy far beyond the individual patient. *See, e.g., Compassion in Dying*, 79 F.3d at 835 ("My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.") (quoting Brief of Amicus Curiae of Ten Surviving Family Members). When a family member assists the suicide, the negative effects can be irremediable. *See id.* at 835-36 & n. 135-36.

a chilling effect on the patient's ability to communicate freely with and receive critical information from his doctor. Second, this concern "is based upon the simplistic assumption that trust implies only that physicians will do no harm. The fact is that many patients now want to trust that their physicians will stay with them and will not abandon them when the only way out of their suffering is to help them to die as they choose." Hall, *Final Act*, at 14.[16]

III. REGULATION OF PHYSICIAN-ASSISTED SUICIDE IS FEASIBLE AND WOULD BETTER SERVE PETITIONERS' INTEREST IN PREVENTING POTENTIAL ABUSE THAN THE CURRENT SECRET PRACTICE .

Although Petitioners and many of their supporting *amici* concede the compelling nature of the suffering of individual terminally ill patients such as those who brought these actions, *see, e.g., Vacco* Pet'r Br. at 19; *Glucksberg* Pet'r Br. at 16; U.S. *Glucksberg* Br. at 21, they nevertheless contend that such patients must be forced to endure intolerable suffering because there is no way to effectively regulate the practice of physician-assisted suicide to ensure that it is limited to such patients and only exercised voluntarily, *see Vacco* Pet'r Br. at 29-31; *Glucksberg* Pet'r Br. at 44-47.[17]

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16. Petitioners' further attempt to justify their criminal ban by contending that, once freed of the prohibition from intentional harm, medical providers might resort to encouraging physician-assisted suicide as a means of reducing health care costs, *see Vacco* Pet'r Br. at 29, ignores the far greater economic incentives providers have for reducing the enormous costs of life-sustaining treatment for the terminally ill. This argument can not, therefore, support the line Petitioners seek to draw.

17. The State of Washington, as well as *amici* States, also argue that holding that a categorical criminal prohibition of physician-assisted suicide puts an undue burden on the exercise of such rights would somehow limit each State's "broad range of discretion" to develop appropriate regulations in this

Medical decisions concerning physician-assisted suicide are, however, no more subject to error or abuse than other end-of-life decisions, such as refusal of life-sustaining treatment, which have been effectively regulated by States for more than two decades. Indeed, the risks involved in such decisions do not essentially differ from the numerous decisions that patients must make concerning procedures that involve a significant risk of mortality.[18]

Both statistical and anecdotal evidence indicate that the practice of physician-assisted suicide, although illegal in virtually all states, is prevalent throughout the United States.[19] Legal

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area. *Glucksberg* Pet'r Br. at 16; *see also id.* at 47-49; *Amici* States Br. at 27-30. To the contrary, however, it would plainly allow States to develop a variety of appropriate substantive and procedural regulatory standards, such as those discussed below.

18. In support of their contention that physician-assisted suicide can not be effectively regulated, Petitioner Vacco and various amici, *see, e.g., Vacco* Pet'r Br. at 24 n.14; AMA *Glucksberg* Br. at 11-12, also point to the 1991 Remmelink Study, which studied the effects of the de facto legalization of both physician-assisted suicide and voluntary euthanasia in the Netherlands. However, a review of that study and its 1996 successor reveals that such reliance is misplaced. Rather, as the authors of the most recent report conclude, their data simply "do not support the idea that physicians in the Netherlands are moving down a slippery slope" towards "less careful end-of-life decision making and . . . the gradual social acceptance of euthanasia performed for morally unacceptable reasons." P.J. van der Maas et al., *Euthanasia, Physician-Assisted Suicide, and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 New Eng. J. Med. 1699, 1705 (1996). To the contrary, the reports show that "Dutch physicians continue to practice physician-assisted dying only reluctantly and under compelling circumstances." Marcia Angell, *Euthanasia in the Netherlands -- Good News or Bad?*, 335 New Eng. J. Med. 1676, 1677 (1996).

19. *See, e.g.*, Back, *Physician-Assisted Suicide in Washington*, at 919 (12% of Washington physicians received requests for assistance in suicide and in nearly 25% of those requests, prescribed a potentially lethal drug); David J. Doukas et al., *Attitudes and Behaviors on Physician-Assisted Death: A Study of Michigan Oncologists*, 13 J. Clinical Oncology 1055, 1058 (1995) (38% of the 250 practicing oncologists in Michigan had been asked to participate in physician-assisted suicide and 18% had done so); Emanuel, *Oncology Patients* at 1808 ("More than 50% of oncologists had received requests for euthanasia or

recognition and regulation of physician-assisted suicide would only foster the Petitioners' interest in ensuring that the practice is limited to appropriate circumstances and is done in a manner that minimizes any potential for abuse.[20]

A. State Regulation Of End-of-Life Decisions Is Already Well-Established.

Legalized physician-assisted suicide would not be the first instance of state regulation of important end-of-life decisions. To the contrary, virtually every jurisdiction in the United States has regulations governing both living wills and decisions concerning the withdrawal or withholding of life-sustaining treatment in the absence of advance patient directives. These regulations require medical professionals to make judgments similar to these involved

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physician-assisted suicide [and] 13.5% said they had participated in physician-assisted suicide"); Terri R. Fried et al., *Limits of Patient Autonomy: Physician Attitudes and Practices Regarding Life-Sustaining Treatments and Euthanasia*, 153 Archives Internal Med. 722, 725-26 (1993) (Rhode Island survey of 393 physicians concluding 18.9% had been asked to prescribe a lethal amount of sleeping pills and 13.3% did so at least once); Melinda A. Lee et al., *Legalizing Assisted Suicide -- Views of Physicians in Oregon*, 334 N. Eng. J. Med. 310, 313 (1996) (21% of Oregon physicians had been asked in the last year to provide physician-assisted suicide and 7% had done so); *see also* David Orentlicher, *Physician Participation in Assisted Suicide*, 262 JAMA 1844, 1844 (1989). These studies most likely underestimate the extent of the practice in the United States because they depend upon self-reporting of an illegal act that can easily be kept secret and because other health care professionals, including nurses, also assist in suicides. *See* David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 New Eng. J. Med. 1374, 1374 (1996) (study of critical care nurses across the country concluding that 17% were asked to assist in a suicide or perform euthanasia and 16% had done so at least once).

20. Furthermore, studies of the attitudes of terminally ill patients suggest that it is the patients who are assumed to be most vulnerable, such as those with limited cognitive ability or lower income or education, who look with least favor on the option of physician-assisted suicide. *See, e.g.*, H.G. Koenig et al., *Attitudes of Elderly Patients and their Families toward Physician-Assisted Suicide*, 156 Archives of Internal Medicine 2240, 2247 (1996).

in physician-assisted suicide and demonstrate how procedural safeguards can ensure that patients make end-of-life decisions competently and voluntarily.

For example, health professionals and lawyers have implemented state laws concerning living wills for more than twenty years.[21] Patient declarations regarding the withdrawal of life support are currently regulated in forty-seven states, the District of Columbia and the Virgin Islands.[22] Regulation in most states

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21. For example, the California Natural Death Act (Cal. Health and Safety Code §§ 7185-7194.5) was enacted in 1976. In addition, since 1991, the federal Patient Self-Determination Act, 42 U.S.C. §§ 1395cc, 1396a (1994), has required health care providers to have written institutional policies regarding living wills and to document whether or not a patient has executed such an instrument. Such institutional policies often mandate the involvement of the hospital ethics committee to oversee the process and the decisions taken with regard to the execution and implementation of living wills.

22. Ala. Code §§ 22-8A-1 to -10; Alaska Stat. §§ 18.12.010 to 18.12.100; Ariz. Rev. Stat. Ann. §§ 36-3201to 36-3262; Ark. Code Ann. §§ 20-17-201 to-218; Cal. Health & Safety Code §§ 7185-7194.5; Colo. Rev. Stat. §§ 15-18-101 to -113; Conn. Gen. Stat. §§ 19a-570 to -580; Del. Code Ann. tit. 16, §§ 2501-2509; D.C. Code Ann. §§ 6-2421 to -2430; Fla. Stat Ann. §§ 765.101-765.401; Ga. Code Ann. §§ 31-32-1 to -12; Haw. Rev. Stat. §§ 327D-1 to 327D-27; Idaho Code §§ 39-4501 to -4509; 755 Ill. Comp. Stat. Ann. §§ 35/1 to 35/10; Ind. Code Ann. §§ 16-36-4-1 to -21; Iowa Code §§ 144A.1 to .12; Kan. Stat. Ann. §§ 65-28,101 to 65-28,109; Ky. Rev. Stat. Ann. §§ 311.621 to 311.644; La. Rev. Stat. Ann. §§ 40:1299.58.1 to 40:1299.58.10; Me. Rev. Stat. Ann., tit. 18-A, §§ 5-801 to -817; Md. Code Ann.., Health-Gen. I §§ 5-601 to 5-618; Minn. Stat. §§ 145B.01 to 145B.17; Miss. Code Ann. §§ 41-41-101 to -121; Mo. Ann. Stat. §§ 459.010 to 459.055; Mont. Code Ann. §§ 50-9-101 to -111, -201 to -206; Neb. Rev. Stat. Ann. §§ 20-401 to -416 and §§ 30-3401 to -3452; Nev. Rev. Stat. §§ 449.535 to 449.690; N.H. Rev. Stat. Ann. §§ 137-H:1 to H:16; N.J. Stat. Ann. § 26:2H-53 to 2H-78; N.M. Stat. Ann. §§ 24-7-1 to -11; N.C. Gen. Stat. §§ 90-320 to -322; N. D. Cent. Code §§ 23-06.4-01 to -14; Ohio Rev. Code Ann. §§ 1337.11 to 1337.17, 2133.01 to 2133.15; Okla. Stat. Ann. tit. 63, §§ 3101.01 to 3101.16; Or. Rev. Stat. §§ 127.505 to 127.660; 20 Pa. Cons. Stat. Ann. §§ 5401-5416; R.I. Gen. Laws §§ 23-4.10-1 to 23-4.10-12, 23-4.11-1 to 23-4.11-14; S.C. Code Ann. §§ 44-77-10 to -160; S.D. Codified Laws §§ 34-12D-1 to 34-12D-22; Tenn. Code Ann. §§ 32-11-101 to -112; Tex. Health & Safety Code Ann. §§ 672.001 to 672.021; Utah Code Ann. §§ 75-2-1101 to -1119; Vt. Stat. Ann. tit. 18, §§ 5251 to 5262; V.I. Code Ann. tit. 19, § 192; Va. Code Ann. §§ 54.1-2981 to -2993; Wash. Rev. Code Ann. §§ 70.122.010 to 70.122.920; W. Va. Code §§ 16-30-1 to -13; Wis. Stat. Ann. §§ 154.01 to

follows a similar pattern. Declarants are restricted to individuals over the age of eighteen who are of "sound mind"[23] or "competent."[24] Further, all declarations must be signed and witnessed,[25] and the patient must have a "terminal," "incurable" or "irreversible" condition, or be "permanently unconscious," before the instructions may be followed.[26] Several other common procedural safeguards include: restrictions on who may act as a witness (*e.g.*, those who stand to benefit financially from the patient's death or those who are employed by the relevant medical facility are barred);[27] a mandatory second opinion as to the patient's

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154.15; Wyo. Stat. Ann. §§ 35-22-101 to -108. The three states that do not regulate living wills have all enacted "health care proxy statutes" which allow designated agents to make health care decisions, including the withdrawal of life support, whenever the patient is no longer able to make treatment decisions. *See* Mass. Gen. Laws Ann. ch. 201D, §§ 1-17; Mich. Comp. Laws §§ 700.496; N.Y. Pub. Health Law §§ 2980 to 2994.

23. *See, e.g.*, Cal. Health and Safety Code § 7186.5(a); Ohio Rev. Code § 1337.12(A)(1); N.H. Rev. Stat. Ann. § 137-H:3; 20 Pa. Cons. Stat. Ann. § 54.04(a).

24. *See, e.g.*, Colo. Rev. Stat. § 15-18-104; Fla. Stat. Ann. §§ 765.102(1), 765.302(1); Mo. Ann. Stat., § 459.015; Tex. Health & Safety Code § 672.003(a); Va. Code Ann. § 54.1-2983.

25. *See, e.g.*, Cal. Health & Safety Code § 7186.5(a); D.C. Code Ann. § 6-2422, Fla. Stat. Ann. § 765.302(1); Tex. Health & Safety Code § 672.003(b); Va. Code Ann. § 54.1-2983.

26. *See, e.g.*, Ark. Code Ann., § 20-17-202; Cal. Health & Safety Code §§ 7185.5(d), 7186.5(b); Conn. Gen. Stat. § 19a-575a; Fla. Stat. § 765.303; 20 Pa. Cons. Stat. Ann. § 5405(2); Va. Code Ann. § 54.1-2983; Wa. Rev. Code §§ 70.122.010, 70.122.030(1).

27. *See, e.g.*, Cal. Health & Safety Code § 7285.5(a); D.C. Code Ann., § 6-2422 (4); Ohio Rev. Code Ann., § 1337.12 (B); Tex. Health & Safety Code § 672.003(c); Wa. Rev. Code § 70.122.030(1).

condition;[28] and record-keeping requirements.[29]

B. Comprehensive Regulations For Physician-Assisted Suicide Have Already Been Promulgated.

Various comprehensive schemes for regulating physician-assisted suicide have already been developed. These include (*i*) the Oregon Death with Dignity Act, (*ii*) the Harvard model statute, so-called because several of its authors are affiliated with Harvard University, and (*iii*) the guidelines promulgated by the Bay Area Network of Ethics Committee ("BANEC").[30] These regulatory schemes draw on the previous extensive experience of health professionals and lawyers in making and regulating other end-of-life decisions. They include the following procedural safeguards:

- Those requesting physician-assisted suicide must be adults suffering from a terminal or intractable and unbearable illness. *See* Harvard Model § 3(a)(2); BANEC Gd. V.A(1); Or. Rev. Stat. § 127.805.

- The request must be voluntary (*i.e.*, free of undue

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28. *See, e.g.*, Cal. Health & Safety Code §7186.5(b); Colo. Rev. Stat. § 15-18-107; Fla. Code Ann. § 765.303(1); D.C. Code § 6-2422 (c); Kan. Stat. Ann. § 65-28, 103(c); Ohio Rev. Code § 1337.11(y); 20 Pa. Cons. Stat. Ann. § 5408.

29. *See, e.g.*, Cal. Health & Safety Code § 7189; Kan. Stat. Ann. § 65-28, 103 (b); Mo. Rev. Stat. §459.015(2); 20 Pa. Cons. Stat. Ann. § 5404 (D); Tex. Health & Safety Code § 672.003(e); Wa. Rev. Code § 70.122.030(1).

30. *See* Oregon Death with Dignity Act, Or. Rev. Stat. §§ 127.800 to 127.995; Charles H. Baron et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996) ("Harvard Model") (attached hereto as Appendix B); Bay Area Network of Ethics Committees (BANEC), *BANEC-Generated Guidelines for Comprehensive Care of the Terminally Ill* (Sept. 1996) ("BANEC Gd.") (attached hereto as Appendix C).

influence), informed, and repeated on at least two occasions. *See* Harvard Model § 3(a)(3)(C), (D); BANEC Gd. V.A(4), F; Or. Rev. Stat. §§ 127.805, 127.830, 127.840.

- A second opinion in writing must be sought to confirm the diagnosis of the patient. *See* Harvard Model § 5(a); BANEC Gd. V.B; Or. Rev. Stat. § 127.820.

- A second opinion as to the mental state of the patient must be submitted in writing. Harvard Model § 5(b); BANEC Gd. V.B; Or. Rev. Stat. § 127.820. In particular, the second physician must confirm that the patient's judgment has not been distorted by clinical depression or other mental illness. *See* Harvard Model § 5(b); BANEC Gd. B; Or. Rev. Stat. § 127.825.[31]

- Patients must be informed of, and offered, all reasonable palliative care options. *See* Harvard Model § 4(a); BANEC Gd. V.C; Or. Rev. Stat. § 127.815.

- Patients must be informed of their diagnosis, prognosis, and the various benefits and burdens of the available medical options, including physician-assisted suicide. *See* Harvard Model § 5(d); BANEC Gd. V.E; Or. Rev. Stat. § 127.815.

- Patients must be counseled to consult with their family. *See* Harvard Model § 4(c); BANEC Gd. V.D; Or. Rev. Stat.

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31. Under the Oregon statute, whenever, in the opinion of the attending or consulting physician, a patient may be suffering from a mental disorder or depression causing impaired judgment, the patient must be referred for counseling and the person performing the counseling must determine that the patient is not suffering from such problems. *See* Or. Rev. Stat. § 127.825.

§ 127.835.

- Patients must be informed that they may consult a third party, *e.g.*, a social worker, or a hospital ethics committee. *See* Harvard Model § 4(b); BANEC Gd. V.D.

- The patient must execute a signed, witnessed request for physician-assisted suicide.[32] The witnesses must be individuals who do not stand to benefit from the patient's death and who are not affiliated with the relevant health care facility. *See* BANEC Gd. V.E; Or. Rev. Stat. § 127.810. In certain cases (*e.g.*, if the patient is in a skilled nursing facility), the presence of a state-appointed witness is required. *See* BANEC Gd. V.E; Or. Rev. Stat. § 127.810(4).

- The patient must be informed that he or she may revoke the request. *See* BANEC Gd. V.G; Or. Rev. Stat. § 127.845.

- All documentation, including the declaration, the opinion of the attending physician, and the second opinions, must be included in the patient's medical record. *See* Harvard Model §§ 4(d)(3), 5(c), 6 (does not include the patient's request); BANEC Gd. V.A-H; Or. Rev. Stat. § 127.855.

- Attending physicians must prepare detailed reports which are either filed with or made available to State health

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32. Model written forms can be found in BANEC Guidelines -- Attached Form #2 and Or. Rev. Stat. § 127.897. The Harvard Model has no equivalent provision and allows an oral request. However, the physician's discussion with the patient regarding the patient's diagnosis and prognosis and the benefits and burdens of the treatment options (including physician-assisted suicide) must be witnessed and either recorded on video or audio tape or transcribed and signed by the patient. Harvard Model § 4(d); *see also* BANEC Gd. V. E; Or. Rev. Stat. § 127.810.

officials.[33]

C. Regulation Of Physician-Assisted Suicide Is Just As Feasible As Regulation Of Other End-Of-Life Decisions.

Each of the key concepts involved in assessing the appropriateness of physician-assisted suicide has been used for years in making and regulating other end-of-life decisions by patients and their doctors. There is no basis for believing that such regulations could not similarly ensure that physician-assisted suicide is appropriately limited to terminally ill patients who have made their decisions competently, voluntarily and with the best available information concerning their medical condition and options.

1. Terminal Illness

Determinations of terminal illness have been used as a basis for end-of-life decisions for more than two decades and form part of the regulatory schemes of virtually all States, including Petitioners New York and Washington.[34] Thus, both physicians and hospital ethics committees have extensive experience in determining when a patient is terminally ill.

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33. For example, under the Harvard model statute, the attending physician must file a detailed report with the state Health Commissioner. *See* Harvard Model § 6. The Commissioner may review the reports and medical records in order to prepare an annual report on the operation and success of the statute. *See id.* § 9(d). The BANEC Guidelines propose the creation of a state registry which would be able to request, for review, the full medical records of all patients, including details of the hastened death. The registry would track complete demographic information and issue an annual report detailing its findings. *See* BANEC Gd. V.K.

34. *See, e.g.*, N.Y. Pub. Health Law § 2961(23); Wash. Rev. Code Ann. § 70.122.020(9).

Although the risk of misdiagnosis can never be entirely eliminated, a number of studies suggest that erroneous prognoses of the terminally ill tend to be overly optimistic. *See, e.g.*, Ronald S. Schonwetter et al., *Estimation of Survival Time in Terminal Cancer Patients: An Impedance to Hospice Admissions*, 6 Hospice J. 65 (1990); Lorna E. Forster et al., *Predicting Life Span For Applicants to Inpatient Hospice*, 148 Archives Internal Med. 2540, 2542 (1988). Moreover, even if an illness is misdiagnosed by a primary physician as "terminal," there are a number of subsequent safeguards and procedures which could reduce the risk of error before physician-assisted suicide would be permitted. For example, the Harvard model statute provides for a mandatory second opinion as to the severity of the patient's condition. Harvard Model § 5(a).

More importantly, legalization of physician-assisted suicide, in contrast to the current secret practice, would ensure that patients will make such decisions based on frank and full discussions with their doctors concerning their medical condition and options and that their doctors can freely consult with other medical professionals. Furthermore, because physician-assisted suicide will be limited to patients whose suffering is severe and untreatable, the risk of an overly pessimistic diagnosis must be weighed against the unendurable condition in which the patient might survive. In such circumstances, an overly optimistic prognosis may risk as severe harm to the patient as an overly pessimistic one. *Cf. Cruzan*, 497 U.S. at 320 (Brennan, J., dissenting) (an erroneous decision to keep alive a patient on life support is just as irrevocable as an erroneous decision to remove life support because the patient's "own degraded existence is perpetuated; his family's suffering is protracted; the memory he leaves behind becomes more and more distorted").

2. Informed Consent

The requirement of informed consent is a concept familiar to all health care professionals as part of any decision to undergo medical treatment and is a well-established feature of the health law of both New York and Washington.[35] Because of the seriousness of the decision to elect physician-assisted suicide, additional safeguards can ensure that the patient has all of the medical information necessary to make her decision and that there is a sufficient record so that the adequacy of the information provided to the patient can be subject to review. For example, the Harvard model statute requires that the responsible physician shall:

> supply to and discuss with the patient all available medical information that is necessary to provide a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits and burdens.

Harvard Model § 4(d). This discussion must be witnessed by two individuals "at least one of whom . . . must not be affiliated with any person that is involved in the care of the patient, [or] . . . stand to benefit personally in any way from the patient's death." *Id.* § 4(d)(1). The medical discussion must be either recorded on video or audio tape or summarized in a document which the patient signs. *See id.* § 4(d)(3). The physician must inform the witnesses that

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35. *See* N.Y. Pub. Health Law § 2441 ("'Voluntary informed consent' means the legally effective knowing consent of an individual or his legally authorized representative, so situated as to be able to exercise free power of choice without undue inducement or any element of force, fraud, deceit, duress, or other form of constraint or coercion."); *Villanueva v. Harrington*, 906 P.2d 374, 376 (Wash. 1995).

they "may question the . . . physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information discussed." *Id.* § 4(d)(2). In addition, the model statute mandates the involvement of at least three health care professionals at different points in the process (the primary physician, consulting physician and licensed psychiatrist, clinical psychologist or psychiatric social worker), all of whom will discuss the matter with the patient. Finally, the written opinion on the patient's competence must specifically address whether the patient's decision is "fully informed." *Id.* §§ 5(a), (b).

3. Voluntariness

Assessments of voluntariness are also a well-established aspect of existing schemes for regulating other end-of-life decisions. For example, most living will statutes include provisions intended to ensure that end-of-life decisions are made voluntarily, such as requirements that multiple witnesses be present at the time the living will is executed. *See supra.* Additional protections can ensure that individuals are not coerced into choosing physician-assisted suicide. For example, the Harvard model statute requires that the patient's request be made on separate occasions at least two weeks apart. Harvard Model § 3(a)(3)(D). In addition, a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient must make a written finding that the patient's judgment is "free of undue influence." *Id.* § 5(b).

4. Competence Or Capacity

Assessments of a patient's capacity to make a medical decision are also a common and well-established aspect of medical practice. Indeed, "[t]here appears . . . to be a developing consensus regarding the meaning of capacity in cases dealing with medical

decision making, including those concerning life-sustaining treatment. This consensus is toward accepting the meaning of capacity implied in the Restatement of Torts [§ 892A], namely the ability to appreciate the nature, extent, or probable consequences of the physician's conduct to which consent is given." 1 Alan Meisel, *The Right to Die* § 3.19, at 100 (2d ed. 1995).[36]

The Harvard model statute again suggests how states can adopt the general standards of competency to the special circumstances of terminally ill patients to ensure that decisions are not "the result of a distortion of the patient's judgment due to clinical depression or any other mental illness." Harvard Model § 3(a)(3)(A); *cf.* Martha Alys Matthews, Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 Cal. L. Rev. 707 (1987) (proposing test for determining competency of patients who seek to hasten death). In order to ensure that the patient fully understands the nature of their decision, the Harvard model statute requires consultation with a licensed psychiatrist, clinical psychologist, or psychiatric social worker, who must provide a written opinion that the patient is not seeking physician-assisted suicide due to clinical depression or mental illness. Harvard Model § 5(b). Well-established criteria exist, such as prior mental illness, and the intensity and consistency of the symptoms, which allow psychiatrists to differentiate between clinical depression and mere feelings of sadness and grief. *See* Block, *Patient Requests*, at 2042.

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In short, all of the assessments that medical professionals would need to make to ensure that physician-assisted suicide is

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36. *See, e.g.*, N.Y. Pub. Health Law § 2980 (3) ("Capacity to make health care decisions' means the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.").

limited to appropriate circumstances are currently being made by physicians in virtually all States -- including those of Petitioners themselves -- in connection with other, equally weighty end-of-life decisions. Numerous proposals have already been developed with extensive procedural protections to minimize the possibility of risk of error or abuse in aiding terminally ill, suffering patients to voluntarily hasten their own deaths. There is no justification, therefore, for a categorical criminal prohibition of the practice.

CONCLUSION

For the reasons stated above, *amici* urge this Court to affirm the decisions of the Courts of Appeals for the Second and Ninth Circuits.

December 10, 1996

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1. The individual medical professionals do not necessarily represent the views of those organizations with which they are affiliated.

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Charles F. McKhann, M.D., Professor of General Surgery and Surgical Oncology, Yale University School of Medicine; Member, Editorial Board, *Cancer Research*; Member, Yale New Haven Hospital Cancer Committee; author of numerous publications regarding cancer research and treatment; preparing a book on physician-assisted suicide.

Janet L. Mitchell, M.D., M.P.H., Chairperson, Department of Obstetrics and Gynecology, Interfaith Medical Center; Obstetrical Consultant, New York City Department of Health Bureau of Maternity Services and Family Planning, National Institutes of Health and Centers for Disease Control and Prevention; former Chief of Perinatology and Director of Special Prenatal Program for Chemically Dependent Women, Harlem Hospital Center; former Director of Ambulatory Perinatology, Boston City Hospital; author

of over 50 publications regarding substance abuse in pregnant women, HIV disease in women and infant and maternal mortality, including Chairperson on the Center for Substance Abuse Treatment panel that wrote the Treatment Improvement Protocols for Substance Using Pregnant Women.

David Orentlicher, M.D., J.D., Associate Professor of Law in Bioethics and Law, Fourteenth Amendment and Professional Responsibility, Indiana University School of Law; former Adjunct Assistant Professor of Medicine, Northwestern University Medical School; former Director, Division of Ethics Standards, and Ethics and Health Policy Counsel, American Medical Association; Member, American Law Institute; Editorial Advisory Board, *Food and Drug Law Journal*; Member, American Association of Bioethics; author of over 80 publications regarding legal and ethical issues in medicine, including physician-assisted death.

Naomi Pless, M.D., Clinical Assistant Professor of Family Medicine, University of Rochester School of Medicine & Dentistry; Co-Director, Community Medicine Program, University of Rochester Department of Family Medicine, Family Medicine Residency Program; Attending Physician, Highland Hospital; Member, American Academy of Family Physicians and the Society of Teachers of Family Medicine.

Edward Pierce, M.D., retired family physician; Chairperson, Merian's Friends; former Michigan State Senator; former Mayor of the City of Ann Arbor, Michigan.

Friedrich K. Port, M.D., M.S., Professor of Internal Medicine and Epidemiology, University of Michigan Medical School; Co-Director, Kidney, Epidemiology & Cost Center; Staff Nephrologist and former Chief, Hemodialysis Unit, Veterans Administration Medical Center, Ann Arbor, Michigan; author of over 100

publications regarding end stage renal disease.

Peter Safar, M.D., Distinguished Professor of Resuscitation Medicine and Endowed Chair in Anaesthesiology and Critical Care Medicine, University of Pittsburgh Medical Center; Founder and Fellow, American College of Critical Care Medicine and American College of Chest Physicians; Founder and former Director, Safar Center for Resuscitation Research; Founder, Departments of Anaesthesiology at National Cancer Institute (Lima, Peru), Baltimore City Hospitals, and University of Pittsburgh Medical Center; Founder, World Association for Disaster and Emergency Medicine; author of over 1,100 publications, including the first textbooks on Respiratory Therapy, Anaesthesiology and Emergency Medicine, and numerous articles and President's Commission studies regarding biomedical ethics and death.

Anthony L. Suchman, M.D., Associate Professor of Medicine and Psychiatry, University of Rochester School of Medicine & Dentistry; Executive Director of Highland PO, Inc.; Fellow, American College of Physicians; Charter Fellow and Senior Facilitator, American Academy for Physician and Patient; Member, managed care committees, Robert Wood Johnson Foundation, Fetzer Institute and the Society for General Internal Medicine; author of numerous publications regarding doctor-patient relationships and medical decision-making.

Griffith D. Thomas, M.D., J.D., practitioner, Anatomic, Clinical and Forensic Pathology; Medical Staff Member, Valley Presbyterian Hospital; Director, Valley Community Clinic; Los Angeles County Bar Association (Bioethics Committee, Subcommittee on Durable Power of Attorney, Subcommittee on AIDS, Subcommittee on Death and Dying); Founder Barristers Hospice/AIDS Project; Joint LACBA/LACMA Committee on Biomedical Ethics; author of several publications regarding AIDS.

Milton Viederman, M.D., Professor of Clinical Psychiatry, Cornell University Medical College; Lecturer in Psychiatry, Columbia College of Physicians and Surgeons; Director, Consultation-Liaison Service, and Attending Psychiatrist, New York Hospital; Adjunct Attending Physician, Memorial Hospital for Cancer & Allied Diseases; Associate Director, Columbia Psychoanalytic Center for Training and Research; Consultant, Rockefeller University Hospital; Life Fellow, American Psychiatric Association; Fellow and Member, Committee on Physician-Assisted Suicide, New York Academy of Medicine; Reviewer, *American Journal of Psychiatry*, *Hospital and Community Psychiatry*; author of nearly 70 publications regarding various aspects of psychiatry, the doctor-patient relationship, bioethics and medical decision-making.

Sidney H. Wanzer, M.D., Physician, Harvard University Health Services; Clinical Instructor in Medicine, Harvard Medical School; Preceptor for residents from Cambridge Hospital on ambulatory care medicine rotation; Member, Advisory Committee, Hemlock Society U.S.A.; author of several publications regarding the ethics and regulation of physician-assisted suicide, including the "Harvard Model statute."

Max Harry Weil, M.D., Ph.D., Clinical Professor of Medicine, Surgery and Anaesthesia, University of Southern California Los Angeles; Adjunct Professor of Medicine, Northwestern University; Visiting Professor of Anaesthesiology, University of Pittsburgh; President of the Institute of Critical Care Medicine; author of numerous publications regarding critical care and decisions at the end of life.

Peter M. Winter, M.D., Peter and Eva Safar Professor of Anaesthesiology and Critical Care Medicine and former Chairman, University of Pittsburgh School of Medicine; Visiting Professor of

Anaesthesiology at 14 medical schools across the United States; Anaesthesiologist-in-Chief, University Health Center Hospitals of Pittsburgh; Member, Advisory Committee and Managed Care Committee, Center for Medical Ethics, University of Pittsburgh School of Medicine; Member, American College of Chest Physicians, American Medical Association, New York Academy of Sciences; Founding Member, American Society of Critical Care Anaesthesiologists and Society of Critical Care Medicine; Chairman, Educational Advisory Board, Association of University Anaesthetists; Editorial Board, *Critical Care Medicine*; author of over 100 publications on critical care medicine, acute respiratory failure and anaesthetic agents.

APPENDIX B

A MODEL STATE ACT TO AUTHORIZE AND REGULATE PHYSICIAN-ASSISTED SUICIDE

SECTION 1. STATEMENT OF PURPOSE

The principal purpose of this Act is to enable an individual who requests it to receive assistance from a physician in obtaining the medical means for that individual to end his or her life when he or she suffers from a terminal illness or from a bodily illness that is intractable and unbearable. Its further purposes are (a) to ensure that the request for such assistance is complied with only when it is fully informed, reasoned, free of undue influence from any person, and not the result of a distortion of judgment due to clinical depression or any other mental illness, and (b) to establish mechanisms for continuing oversight and regulation of the process for providing such assistance. The provisions of this Act should be liberally construed to further these purposes.

SECTION 2. DEFINITIONS

As used in this Act,

(a) "Commissioner" means the Commissioner of the Department.

(b) "Department" means the Department of Public Health [or similar state agency].

(c) "Health care facility" means a hospital, hospice, nursing home, long-term residential care facility, or other institution providing medical services and licensed or operated in accordance with the law of this state or the United States.

(d) "Intractable and unbearable illness" means a bodily

disorder (1) that cannot be cured or successfully palliated, and (2) that causes such severe suffering that a patient prefers death.

(e) "Medical means of suicide" means medical substances or devices that the responsible physician prescribes for or supplies to a patient for the purpose of enabling the patient to end his or her own life. "Providing medical means of suicide" includes providing a prescription therefor.

(f) "Patient's medical record" means (1) in the case of a patient who is in a health care facility, the record of the patient's medical care that such facility is required by law or professional standards to compile and maintain, and (2) in the case of a patient who is not in such a facility, the record of the patient's medical care that the responsible physician is required by law or professional standards to compile and maintain.

(g) "Person" includes any individual, corporation, professional corporation, partnership, unincorporated association, government, government agency, or any other legal or commercial entity.

(h) "Responsible physician" means the physician, licensed to practice medicine in this state, who (1) has full or partial responsibility for treatment of a patient who is terminally ill or intractably and unbearably ill, and (2) takes responsibility for providing medical means of suicide to the patient.

(i) "Terminal illness" means a bodily disorder that is likely to cause a patient's death within six months.

SECTION 3. AUTHORIZATION TO PROVIDE ASSISTANCE

(a) It is lawful for a responsible physician who complies in all material respects with Sections 4, 5, and 6 of this Act to provide a

patient with medical means of suicide, provided that the responsible physician acts on the basis of an honest belief that

(1) the patient is eighteen years of age or older;

(2) the patient has a terminal illness or an intractable and unbearable illness; and

(3) the patient has made a request of the responsible physician to provide medical means of suicide, which request

(A) is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness;

(B) represents the patient's reasoned choice based on an understanding of the information that the responsible physician has provided to the patient pursuant to Section 4(d) of this Act concerning the patient's medical condition and medical options;

(C) has been made free of undue influence by any person; and

(D) has been repeated without self-contradiction by the patient on two separate occasions at least fourteen days apart, the last of which is no more than seventy-two hours before the responsible physician provides the patient with the medical means of suicide.

(b) A responsible physician who has provided a patient with medical means of suicide in accordance with the provisions of this Act may, if the patient so requests, be present and assist the patient

at the time that the patient makes use of such means, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

SECTION 4. DISCUSSION WITH PATIENT AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) offer to the patient all medical care, including hospice care if available, that is consistent with accepted clinical practice and that can practicably be made available to the patient for the purpose of curing or palliating the patient's illness or alleviating symptoms, including pain and other discomfort;

(b) offer the patient the opportunity to consult with a social worker or other individual trained and experienced in providing social services to determine whether services are available to the patient that could improve the patient's cares sufficiently to cause the patient to reconsider his or her request for medical means of suicide;

(c) counsel the patient to inform the patient's family of the request if the patient has not already done so and the responsible physician believes that doing so would be in the patient's interest; and

(d) supply to and discuss with the patient all available medical information that is necessary to provide the basis for a reasoned decision concerning a request for medical means of suicide, including all such information regarding the patient's diagnosis and prognosis, the medical treatment options and the medical means of suicide that can be made available to the patient, and their benefits

and burdens, all in accordance with the following procedures:

(1) at least two adult individuals must witness the discussion required by this paragraph (d), at least one of whom (A) is not affiliated with any person that is involved in the care of the patient, and (B) does not stand to benefit personally in any way from the patient's death;

(2) the responsible physician shall inform each witness that he or she may question the responsible physician and the patient to ascertain that the patient has, in fact, heard and understood all of the material information pursuant to this paragraph (d), and discussed pursuant to this paragraph (d); and

(3) the responsible physician shall document the discussion with the patient held pursuant to this paragraph (d), using one of the following methods:

(A) an audio tape or a video tape of the discussion, during which the witnesses acknowledge their presence; or

(B) a written summary of the discussion that the patient reads and signs and that the witnesses attest in writing to be accurate.

The documentation required by this subparagraph (3) must be included and retained with the patient's medical record, and access to and disclosure of such records and copies of them are governed by the provisions of Section 10 of this Act.

SECTION 5. PROFESSIONAL CONSULTATION AND DOCUMENTATION

Before providing medical means of suicide to a patient pursuant to Section 3 of this Act, the responsible physician shall

(a) secure a written opinion from a consulting physician who has examined the patient and is qualified to make such an assessment that the patient is suffering from a terminal illness or an intractable and unbearable illness;

(b) secure a written opinion from a licensed psychiatrist, clinical psychologist, or psychiatric social worker who has examined the patient and is qualified to make such an assessment that the patient has requested medical means of suicide and that the patient's request meets the criteria set forth in Sections 3(a)(3)(A), 3(a)(3)(B), and 3(a)(3)(C) of this Act to the effect that the request is not the result of a distortion of the patient's judgment due to clinical depression or any other mental illness, is reasoned, is fully informed, and is free of undue influence by any person; and

(c) place the written opinions described in paragraphs (a) and (b) of this section in the patient's medical record.

SECTION 6. RECORDING AND REPORTING BY THE RESPONSIBLE PHYSICIAN

Promptly after providing medical means of suicide to a patient, the responsible physician shall (a) record the provision of such means in the patient's medical record, (b) submit a report to the Commissioner on such form as the Commissioner may require pursuant to Section 8(a) of this Act, and (c) place a copy of such report in the patient's medical record.

SECTION 7. ACTIONS BY PERSONS OTHER THAN THE RESPONSIBLE PHYSICIAN

(a) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may, if the patient so requests, be present and assist at the time that the patient makes use of medical means of suicide, provided that the actual use of such means is the knowing, intentional, and voluntary physical act of the patient.

(b) A licensed pharmacist, acting in accordance with the laws and regulations of this state and the United States that govern the dispensing of prescription drugs and devices and controlled substances, may dispense medical means of suicide to a person who the pharmacist reasonably believes presents a valid prescription for such means.

(c) An individual who acts on the basis of an honest belief that the requirements of this Act have been or are being met may counsel or assist the responsible physician in providing medical means of suicide to a patient.

SECTION 8. RECORD KEEPING BY THE DEPARTMENT

(a) The Commissioner shall by regulation specify a form of report to be submitted by physicians pursuant to Section 6(b) of this Act in order to provide the Department with such data regarding the provision of medical means of suicide as the Commissioner determines to be necessary or appropriate to enable effective oversight and regulation of the operation of this Act. Such report shall include, at a minimum, the following information:

(1) the patient's diagnosis, prognosis, and the alternative medical treatments, consistent with accepted clinical

practice, that the responsible physician advised the patient were practicably available;

(2) the date on which and the name of the health care facility or other place where the responsible physician complied with the patient's request for medical means of suicide, the medical means of suicide that were prescribed or otherwise provided, and the method of recording the discussion required by Section 4(d) of this Act;

(3) the patient's vital statistics, including county of residence, age, sex, race, and marital status;

(4) the type of medical insurance and name of insurer of the patient, if any;

(5) the names of the responsible physician, the medical and mental health consultants who delivered opinions pursuant to Section 5 of this Act, and the witnesses required by Section 4(d) of this Act; and

(6) the location of the patient's medical record.

(b) The Commissioner shall require that the report described in paragraph (a) of this section not include the name of the patient but shall provide by regulation for an anonymous coding or reference system that enables the Commissioner or the responsible physician to associate such report with the patient's medical record.

SECTION 9. ENFORCEMENT AND REPORTING BY THE DEPARTMENT

(a) The Commissioner shall enforce the provisions of this Act

and shall report to the Attorney General and the appropriate board of registration [or similar state agency] any violation of its provisions.

(b) The Commissioner shall promulgate such rules and regulations as the Commissioner determines to be necessary or appropriate to implement and achieve the purposes of this Act and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Board of Registration in Medicine [or similar state agency] for such Board's review and advice.

(c) The Board of Registration in Medicine [or similar state agency] may promulgate no rule or regulation inconsistent with the provisions of this Act or with the rules and regulations of the Department promulgated under it and shall, at least ninety days prior to adopting any rule or regulation affecting the conduct of a physician acting under the provisions of this Act, submit such proposed rule or regulation to the Commissioner for the Commissioner's review and advice.

(d) The Commissioner shall report to the Legislature annually concerning the operation of this Act and the achievement of its stated purposes. The report of the Commissioner shall be made available to the public upon its submission to the Legislature. In order to facilitate such annual reporting, the Commissioner may collect and review such information as the Commissioner determines to be helpful to the Department, the Board of Registration in Medicine [or similar state agency], or the Legislature and may by regulation require the submission of such information to the Department.

SECTION 10. CONFIDENTIALITY OF RECORDS AND REPORTS

(a) The information that a person acting under this Act obtains from or about a patient is confidential and may not be disclosed to any other person without the patient's consent or the consent of a person with lawful authority to act on the patient's behalf, except as this Act or any other provision of law may otherwise require.

(b) The report that a responsible physician files with the Department pursuant to Section 6(b) of this Act is confidential, is not a public record, and is not subject to the provisions of [the state public records statute or freedom of information act].

SECTION 11. PROVIDER'S FREEDOM OF CONSCIENCE

(a) No individual who is conscientiously opposed to providing a patient with medical means of suicide may be required to do so or to assist a responsible physician in doing so.

(b) A health care facility that has adopted a policy opposed to providing patients with medical means of suicide and has given reasonable notice of such policy to its staff members may prohibit such staff members from providing such means to a patient who is within its facilities or under its care.

SECTION 12. PATIENT'S FREEDOM FROM DISCRIMINATION

(a) No physician, health care facility, health care service plan, provider of health or disability insurance, self-insured employee health care benefit plan, or hospital service plan may require any individual to request medical means of suicide as a condition of eligibility for service, benefits, or insurance. No such physician or

entity may refuse to provide medical services or medical benefits to an individual because such individual has requested medical means of suicide, except as Section 11 of this Act permits.

(b) A patient's use of medical means of suicide to end such patient's life in compliance with the applicable provisions of this Act shall not be considered suicide for the purpose of voiding a policy of insurance on the life of such patient.

SECTION 13. LIABILITY

(a) No person who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to an individual shall be subject to civil or criminal liability therefor.

(b) No individual who has acted in compliance with the applicable provisions of this Act in providing medical means of suicide to a patient shall be subject therefor to professional sanction, loss of employment, or loss of privileges, provided that such action does not violate a policy of a health care facility that complies with Section 11(b) of this Act.

(c) Except as provided in paragraphs (a) and (b) of this section, this Act does not limit the civil, criminal, or disciplinary liability of any person for intentional or negligent misconduct.

SECTION 14. CRIMINAL PENALTIES

In addition to any other civil, criminal, or disciplinary liability that he or she may otherwise incur thereby, an individual who willfully violates Section 3, 4, 5, 6, or 7 of this Act is guilty of a [specify grade of offense].

APPENDIX C

BAY AREA NETWORK OF ETHICS COMMITTEES

BANEC-GENERATED GUIDELINES FOR
COMPREHENSIVE CARE OF THE TERMINALLY ILL

(NOTE: These guidelines are intended for use regardless of the patients' residence -- home, hospital, hospice, clinic, or extended care facility -- as they approach death.)

I. The ultimate responsibility for the care of the patient, pertaining to end-of-life decisions and treatments, resides with the patient's physician.

II. The primary care physician is qualified to provide appropriate care, with or without consultation, for the great majority of patients who are dying.

III. The care of patients experiencing "difficult deaths," those undergoing (in their judgment) intolerable or prolonged suffering as they die, or patients who are making complex and irreversible decisions about end-of-life (including the decision to hasten death), may fall out of the range of skills of many primary care physicians.

Hospice programs have extremely effective teams which provide medical care had help patients with their decisions about end-of-life treatments. Certain physicians in the medical community are also recognized to have special expertise in palliative, end-of-life care. For those patients who face difficult deaths, or those who are making complex and irreversible decisions about terminal care (including a request for physician aid in hastening their death), THE BANEC GUIDELINES URGE REFERRAL TO A HOSPICE PROGRAM AND/OR CONSULTATION WITH A PHYSICIAN EXPERIENCED IN

PALLIATIVE CARE (including, but not limited to, pain control). Many patients, given appropriate and skilled palliative end-of-life care, will withdraw their requests for a hastened death.

IV. At times, in spite of skilled physical, psychological, spiritual and social care, an adult, mentally competent and terminally ill patient will desire a physician's aid in hastening death.

V. These guidelines urge that, before a physician aids a patient to hasten his or her death, the following occur (with specific documentation in the patient's hospital chart and/or outpatient medical records):

(NOTE: No physician, nurse, physician-assistant, pharmacist, or other health care worker is required to participate in the act of hastening a patient's death, nor in the patient's evaluation for such an act. However, these guidelines recommend that participation practitioners who exclude themselves from such participation respond to a patient's request for a hastened death by advising that patient of his or her right to obtain consultation from other practitioners, and/or facilitating the transfer of care should the patient so request.)

Chart documentation should include:

A) The primary care physician's ascertaining of:

1) The terminal diagnosis (a reasonable certainty of death within six months provided the disease runs its expected course, ascertained by review of the medical records and pertinent history and physical examination).

2) An assessment to confirm that, in the best judgement of the physician, the patient is mentally competent and not suffering from a depression that impairs decision making capability. (IT IS HIGHLY RECOMMENDED THAT PHYSICIANS NOT EXPERIENCED WITH SUCH AN EVALUATION SEEK APPROPRIATE AID, WITH THEIR PATIENT'S CONSENT, FROM OTHER PRACTITIONERS IN THE MEDICAL, PSYCHOLOGICAL, OR SOCIAL SERVICES COMMUNITY.)

3) That high-quality palliative care, by hospice and/or a physician recognized to have expertise in palliative care, has been made accessible to the patient.

4) That, to the best of the physician's knowledge, the patient's choice to hasten death has been freely made, independent of financial, family, health insurance, or other coercion.

B) A second opinion to confirm the four points noted above by the primary care physician. These guidelines strongly recommend that the second opinion be obtained from a physician recognized to have expertise in palliative end-of-life care.

C) Documentation of the patient's evaluation by a hospice program and/or physician with palliative care expertise (this can coincide with the second opinion noted above). Documentation should also be made of the palliative-care recommendations resulting from this evaluation, and the ways in which they have or have not been followed.

Alternately, documentation should be made that the patient declines an evaluation for improved palliative care. These guidelines recommend that these patients sign a form (see

attached) to indicate an understanding that they have waived a medical evaluation that could offer care with significant potential for improving their quality of life as they die.

D) The patient has been counseled that a decision to hasten death should, if at all possible, be discussed in detail with family members, loved ones, and others who are likely to be significantly affected by this decision.

The patient has also been counseled that the hospital and hospice medical ethics committees are valuable and willing to discuss his/her care, and the decision to hasten death, with the patient and/or family.

E) A witnessed consent form should be signed by the patient (see example attached), to include full disclosure of the illness, the procedure to aid the patient in hastening death and the associated risks, and a statement that other medical options exist (including hospice care) that might provide further comfort without hastening death.

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or

adoption, or be named in the patient's will. For patients in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

F) A second witnessed signature by the patient must be obtained, no sooner than 48 hours after the first signature.

G) Before aiding the patient in hastening death, there should be chart documentation of verbal counseling that the patient has the right, at any time, to change his or her mind and to return to care that includes the involvement of a hospice team or another physician experienced in palliative care.

H) Chart documentation that the physical process of hastening death was initiated and completed by the patient: These guidelines emphasize that the physician may aid the patient in the process of hastening death (i.e. by provision of oral or injectable medication, or the starting and maintaining of intravenous access), but it should be the patient's own physical effort that initiates and completes the process.

(NOTE: In the BANEC discussions of this document, a significant minority felt that section H draws an artificial mechanical boundary between a "patient initiated" hastened death and a physician's act of administration of drugs once other guideline recommendations have been met. However, since the 9th Circuit Court addressed only physician assisted suicide, the final BANEC guidelines reflect this limitation and refer only to a "patient initiated and completed" process.)

I) These guidelines emphasize that, although it is the patient who undertakes the proximate action that leads to the hastened death, a physician or the physician's designee responsible for the care of the patient should remain immediately and continuously available to the patient and family until death has occurred.

J) The cause of death on the death certificate should be listed as the underlying disease.

K) Reporting: These guidelines urge that a system similar to that of the California Tumor Registry (including the confidentiality of information) be established to which all cases of physician aid in the hastening of a patient's death be reported. This registry would be able to request, for review, the full medical records of the patient, including details of the hastened death. The registry should track complete demographic information and issue an annual report detailing its findings. This report should be accessible to the public.

It is also recommended that existing hospital, hospice and community clinic peer-review organizations include cases of aid in hastening deaths in their mandate of review.

This document is a blueprint for potential policy, to be used as deemed appropriate by individuals or organizations. The Bay Area Network of Ethics Committees provides a forum for open, independent discussion of ethical issues in healthcare. Opinions and guidelines proffered via BANEC are not necessarily representative of or endorsed by any individual or organization participating in BANEC discussions, and are non-binding in all cases.

FORM #1: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

DOCUMENTATION OF OFFER OF CONSULTATION
AND SERVICES BY HOSPICE OR OTHER
PALLIATIVE CARE EXPERT

NAME:_____

My physician, _____, has recommended that I be evaluated by a hospice program and/or another physician, both of which have special expertise in controlling the emotional, spiritual and physical suffering that can be associated with dying. It is my understanding that hospice programs and such physicians can provide the optimal treatment for terminally ill patients such as myself, and that such treatment might include improved treatment for the pain associated with my illness, treatment and counseling for possible depression or other psychological or social issues, or other problems related to my condition. I further understand that while such treatments will not cure my condition or significantly extend my life, they do have the potential to improve my quality of life. It has been explained to me that a consultation with hospice is readily available to me, and that hospices can make arrangements that will not place additional financial burdens on myself or my family while they provide such services.

After due consideration of this information and offer of referrals, I hereby certify that:

- ☐ I decline the recommendation of a consultation with hospice personnel or physician; or
- ☐ I have accepted the referral and have consulted with (check one or more):

- ☐ Hospice representatives
- ☐ Another physician as referred to by my primary physician
- ☐ Other: _____

_____ _____
Signature of patient Date

_____ _____
Signature of witness Date

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or adoption, or be named in the patient's will. For patients In a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

_____ _____
Signature of primary physician Date

_____ _____
Signature of translator (if applicable) Date

FORM 2: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

INFORMED CONSENT-- REQUEST FOR
PHYSICIAN ASSISTED DEATH

Patient's name: _____

I, the above-named patient, being of sound mind, have of my own free will and in consultation with my physician and others close to me, decided that it is my desire to end my life. I hereby certify that:

I am an adult resident of the State of California;

I believe, and my physicians agree, that I am mentally competent to make decisions regarding my life and death;

I have a confirmed terminal diagnosis with a reasonable prediction that, if the disease runs its expected course, I will die within six months of this date;

I am making this choice to hasten death of my own free will and have not been convinced or coerced to do so by any other persons or party, including any insurer or payor involved in the finances of my health care;

I have been offered full use of medical and hospice services and expertise for the improvement of my condition and quality of life, including management of my pain and discomfort; and have either availed myself of such consultations or have declined to do so;

I have also been offered consultation with an ethics committee of a hospice or hospitals and have or have not undertaken this consultation in accordance with my best judgement;

I have, in accordance with my best judgment, discussed (or chosen not to discuss) this final decision with any members of my family or others who will be affected by my death;

I have discussed the process to be utilized to hasten my death, its risks, and alternatives, and have chosen this method as my preferred means of ending my life;

I retain the right at any time to change my mind and withdraw my request to die. I understand that all other options for care, including hospice and other measures that are likely to make me more comfortable, continue to be available to me at all times.

First request: _____
Signature

Date:_____ Time:_____

Second request: _____
Signature

Date:_____ Time:_____
(Must be 48 hours from first request)

Signature of witnesses of patient's first signature: (NOTE: The selection of witness is in accordance with the regulations now established for the signing of a Durable Power of Attorney for Health Care Decisions).

#1: _____
Name and Signature
Date: _____ Time: _____

#2: _____
Name and Signature
Date: _____ Time: _____

Signature of witness of patient's second signature:

#1: _____
Name and Signature
Date: _____ Time: _____

#2: _____
Name and Signature
Date: _____ Time: _____

Name and signature(s) of translator (if applicable):_____
Date: _____ Time: _____

The witnessing procedure should be in accordance with that now established for the signing of a Durable Power of Attorney for Health Care Decisions, i.e.: "(1) Two qualified adult witnesses

who are personally known to the patient (or to whom the patient provides evidence of his/her identity), and who are present when the patient signs and acknowledges the signature, or (2) acknowledged before a notary public in California. If the witness is other than a notary public, the law provides that none of the following be used: (1) a health care provider or an employee of a health care provider, (2) an operator or an employee of a community care facility or residential care facility for the elderly. Additionally, at least one of the witnesses cannot be related to the patient by blood, marriage, or adoption, or be named in the patient's will. For patients in a skilled nursing facility, one of the witnesses must be a patient advocate or ombudsman."

For patients and/or witnesses who are not able to understand the consent form in English, the forms will be provided in a language they can understand, or the signatures should be accompanied by that of a competent translator.

FORM 3: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

REPORT OF A PHYSICIAN-ASSISTED DEATH
(To be completed by the patient's primary physician)

(NOTE: All cases of assisted death should be reported to an appropriate organization. Until such time as an official reporting entity has been established, the BANEC guidelines recommend reporting to the local Health Department, hospital or hospice ethics committee, or an established peer review or quality assurance committee.)

This information will be held confidential and will be reviewed for compliance with recommended standards of practice only. It is hereby agreed that the patient's complete medical records may be requested by such a review committee, and I hereby agree to provide these records if so requested.

Patient name (or identifying code): _____
Patient's date of birth: _____ Age: _____ Sex: _____
Ethnicity: _____
Physician: _____
Patient's diagnosis: _____
Second physician who confirmed terminal diagnosis: _____
Date of death: _____
Location of death: (Institution/home/or?): _____
Physician's relation to patient (check one):

- ☐ I have been the patient's primary physician for ____ months/yrs.
- ☐ Patient was referred to me to deal with the illness/symptoms which led to the request for hastened death. Date of referral: __

☐ I believe patient was referred to me specifically regarding the hastening of death. Date of referral: _____

First witnessed request for a hastened death:
Date: _____ Time: _____

Second witnessed request for a hastened death:
Date: _____ Time: _____

Diagnosis and symptoms leading to patient's request: _____

Was patient referred for palliative care/hospice consultation:
☐ Yes ☐ No
Did the patient accept this consultation: ☐ Yes ☐ No
If Yes: Date of consultation: _____
By whom: _____
Outcome: _____

Please attach copies of signed forms:
1) Documentation of Offer of Consultation and Services by Hospice or Other Palliative Care Expert.
2) Informed Consent for Physician Assisted Death.
3) Physician Checklist in Assisted Death Cases.

Location of patient's medical records: _____

Mode of assisted dying utilized: _____

Other comments (use other side of form and additional pages as needed).

FORM #4: (two sides)

BANEC-generated guidelines for
Appropriate Care of the Terminally Ill

PHYSICIAN CHECKLIST IN ASSISTED DEATH CASES
(to be completed before the hastening of a patient

Patient's name: _____
Physician's name: _____

Prior to assisting in the death of a patient, please confirm the following:

☐ The patient is an adult resident of California.
☐ As the patient's physician, I am well aware of the patient's medical history, condition, diagnosis and prognosis.
☐ The patient's condition is terminal, with death otherwise expected to occur within six months of this date.
☐ A second physician has confirmed this terminal diagnosis.
☐ The patient is mentally competent and able to exercise rational thought processes in making decisions regarding their health care.
☐ High-quality palliative care, by hospice and/or physicians qualified to provide such care, has been offered to the patient, with full understanding that such care might result in an improved quality of life in the patient's remaining days.
☐ If such care has been refused by patient, such refusal has been documented by signed consent form.
☐ To the best of the physician's knowledge, the patient's choice to die has been freely made, independent of financial, family, health insurance, or other sources of coercion.
☐ The patient has been offered consultation with an ethics committee.

- ☐ The patient has been offered counseling by psychiatrist, therapist, social service worker, clergy or other.
- ☐ The patient has been counseled to discuss his/her decision with any family members, loved ones, or others who will be affected by this decision.
- ☐ The patient has made the required two signed, witnessed requests, at least 48 hours apart, for a hastened death.
- ☐ The patient has been offered appropriate means by ending his/her life, with full disclosure of the process, pros and cons of each, and has made an informed choice of which intervention will be utilized.
- ☐ At the time of the procedure, the patient is still competent, has made a third, final request, with witness(es) present, and has been advised that the procedure may be halted at any time upon the patient's request, with a return to optimal palliative care as an option.
- ☐ A healthcare professional (physician or nurse) with expertise in this area has been identified who will remain immediately and continuously available to assure that distressing symptoms are minimized via appropriate palliative means.

Following death, the usual confirmation and reporting requirements are in effect, with the addition of the reporting form for physician-assisted death.

NARRATIVE SECTION (OPTIONAL): PLEASE UTILIZE THE BACK OF THIS FORM AND/OR ADDITIONAL PAGES TO ADD ANY COMMENTS DEEMED APPROPRIATE REGARDING THIS PATIENT'S CASE.

_____ _____

Physician's signature Date

(54) (52)

Nos. 95-1858, 96-110

Supreme Court, U.S.
FILED
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON and CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D., THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., PH.D.,

Respondents.

On Writs of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

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BRIEF OF 36 RELIGIOUS ORGANIZATIONS, LEADERS AND SCHOLARS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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38 pp

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The American Humanist Association
The Board of Directors of The Society for Humanistic Judaism
The Cather Church
The Congress of Secular Jewish Organizations
The Episcopal Diocese of Newark
The Unitarian Universalist Association
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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES iii

INTEREST OF THE AMICI 1

SUMMARY OF ARGUMENT 1

ARGUMENT 3

I. THE WASHINGTON AND NEW YORK BANS ON PHYSICIAN-ASSISTED SUICIDE BURDEN CORE LIBERTY INTERESTS PROTECTED BY THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT AND THE RELIGION CLAUSES OF THE FIRST AMENDMENT 4

A. The Interests Reflected In The Free Exercise Clause And The Liberty Component Of The Due Process Clause Establish That Physician-Assisted Suicide Is A Core Constitutionally Protected Liberty 6

1. Religious Organizations And Religious Individuals Have Taken A Wide Array Of Positions On The Morality Of Physician-Assisted Suicide 6

2. A Terminally Ill Person's Decision To Hasten Death Is The Sort Of Personal, Intimate, Often Spiritual Decision To Which The First And Fourteenth Amendments Afford Protection . . 10

B. The Interests Reflected In The Establishment Clause Confirm That Physician-Assisted Suicide Is A Core Constitutionally Protected Liberty 16

II. THE ASSERTED INTERESTS OF WASHINGTON AND NEW YORK CANNOT JUSTIFY THE TOTAL PROHIBITION UPON THE EXERCISE OF A CORE CONSTITUTIONALLY PROTECTED LIBERTY . . 21

CONCLUSION 24
APPENDIX 1a

TABLE OF AUTHORITIES

Page

Cases

Board of Education of Kiryas Joel Village School District v. Grumet, 114 S. Ct. 2481 (1994) 16
Cantwell v. Connecticut, 310 U.S. 296 (1940) 10
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Doe v. Bolton, 410 U.S. 179 (1973) 10
Edwards v. Aguilard, 482 U.S. 578 (1987) 3, 20
Epperson v. Arkansas, 393 U.S. 97 (1968) 20
Everson v. Board of Education, 330 U.S. 1 (1947) 15
Hales v. Petit, 75 Eng. Rep. 387 (1562) 19
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TABLE OF AUTHORITIES (Cont'd)

Page

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TABLE OF AUTHORITIES (Cont'd)

Page

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Page

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INTEREST OF THE AMICI*

Amici are a diverse array of religious organizations, leaders, and scholars as well as advocates of religious liberty.[1] They have in common their dedication to the personal liberties and religious freedoms of all Americans as well as their concern for the plight of the terminally ill. Many of the individual *amici* counsel and comfort terminally ill people, and are thus familiar with their physical, emotional, and spiritual suffering and their struggle over the intensely personal decision to hasten an inevitable death. This decision implicates issues of great spiritual significance — issues that are not viewed in the same manner by all religious denominations or their adherents.

The interest of *amici* in these cases is to ensure that terminally ill Americans of all faiths are free to make decisions about the time, place, and manner of death that reflect their personal understanding of life's meaning, reduce the suffering of their bodies and their minds, and conform to their own ethical and spiritual values. While the government may properly regulate this choice to assure that it is truly voluntary and informed, the government may not proscribe the choice altogether, which would undermine the interests protected by the Free Exercise and Establishment Clauses of the First Amendment as well as the liberty component of the Fourteenth Amendment's Due Process Clause.

SUMMARY OF ARGUMENT

The right of a competent, terminally ill individual to end his or her life with the aid of a physician is one of the most important liberties protected by the Due Process Clause. That much is clear from *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), in which this Court endorsed the second Justice Harlan's vision of the liberty guaranteed by the Due Process Clause. Justice

---

* Counsel for both petitioners and respondents have consented to the filing of this brief *amici curiae*. Their consents are on file with the Clerk of the Court.

[1] *Amici* are described in greater detail in the Appendix to this brief.

Harlan's analysis, articulated most forcefully in his dissenting opinion in *Poe v. Ullman,* 367 U.S. 497, 543 (1961), requires courts — using "a reasonable and sensitive judgment" — to determine where, along the "rational continuum" of liberties from the most insignificant to the most fundamental, a particular interest lies. In making these judgments, courts should consider not only the liberties guaranteed by the text of the Constitution, but also the "purposes of those guarantees and . . . the reasons for their statement by the Framers." *Id.*

Amici urge that physician-assisted suicide is one of the most important liberties protected by the Due Process Clause, implicating as it does "the right to define one's own concept of . . . the mystery of human life." *Casey,* 505 U.S. at 851. Our long tradition of individual religious liberty and government noninterference with religious decisions, exemplified by the religion clauses of the First Amendment, serves to confirm that the "perplexing question" of physician-assisted suicide, with its "unusually strong moral and ethical overtones," *Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261, 277 (1990), is an intimate, personal, and ultimately spiritual decision appropriately reserved to the individual's own conscience.

The purposes and reasons behind the Free Exercise Clause bear this out. The many diverse religious faiths represented in this country have many diverse views on the theological and moral propriety of physician-assisted suicide. Some religious denominations absolutely oppose physician-assisted suicide in all instances. Others, while stating no formal church position, have taken the position that an individual's decisions about death should be honored. Still others affirmatively support "the right to self-determination in dying." In the light of this diversity of religious views on the subject, the Due Process Clause's liberty guarantee should be understood to protect a competent, terminally ill adult's decision to end his or her life (or not) with the aid of a physician, just as the Free Exercise Clause protects an individual's right "to maintain theories of life and of death and of the hereafter." *United States v. Ballard,* 322 U.S. 78, 86 (1944).

Similarly, because the common-law's historical bans upon suicide are rooted in the incorporation of Roman Catholic canon law into the English common law, laws banning physician-assisted suicide raise serious Establishment Clause concerns. Laws that endorse one religious view over others, and have overtly religious purposes, are irreconcilable with the values underlying the Establishment Clause. *Lee v. Weisman,* 505 U.S. 577, 587-88 (1992); *Edwards v. Aguilard,* 482 U.S. 578, 592-93 (1987).

Finally, the Washington and New York bans upon physician-assisted suicide cannot survive the "particularly careful scrutiny" — that is, strict scrutiny — required by the Due Process Clause. *Casey,* 505 U.S. at 848-51. While state regulations designed to assure competence and voluntariness might be appropriate, these states' total bans upon this right are not the least restrictive means for furthering any compelling state interest.

ARGUMENT

This Court has endorsed the second Justice Harlan's vision of the substantive liberty guarantee of the Fourteenth Amendment's Due Process Clause. *See, e.g., Planned Parenthood v. Casey,* 505 U.S. 833 (1992). Justice Harlan recognized that the Due Process Clause requires courts to balance, carefully, the two primary — yet often conflicting — aspirations of a free society: the "liberty of the individual," on the one hand, and "the demands of organized society," on the other. *Poe v. Ullman,* 367 U.S. 497, 542 (1961) (Harlan, J., dissenting); *see also Casey,* 505 U.S. at 850; *Rochin v. California,* 342 U.S. 165, 171-72 (1952).[2]

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[2] This accommodation of individual and state interests allows for a wide range of legitimate regulation. Only as the burden imposed on a protected right becomes increasingly direct and substantial must the asserted state interest be strong and the regulation narrowly tailored to serve that interest. Accordingly, although all infringements of protected liberties are subject to a careful balancing of the individual's interest against the government's interest, strict scrutiny applies only when the government unduly burdens or proscribes a protected right. *Planned*

The end result of this balancing is clear in these cases: A competent, terminally ill person's ability to choose to hasten his or her death is a constitutionally protected "liberty of the individual," which is derived not only from the "liberty" component of the Due Process Clause but also from the religion clauses of the First Amendment. The "demands of organized society" do not justify the absolute bans imposed on this liberty by Washington and New York.

I. THE WASHINGTON AND NEW YORK BANS ON PHYSICIAN-ASSISTED SUICIDE BURDEN CORE LIBERTY INTERESTS PROTECTED BY THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT AND THE RELIGION CLAUSES OF THE FIRST AMENDMENT

The term "liberty" in the Fourteenth Amendment's Due Process Clause is, admittedly, broad, encompassing every "liberty" from the most insignificant to the most fundamental. *See Poe*, 367 U.S. at 543 (Harlan, J., dissenting) (observing that liberty encompasses, at a minimum, "freedom from all substantial arbitrary impositions and purposeless restraints") (citing cases). As this Court recently reiterated in *Casey*, it is the task of judges, using "'a reasonable and sensitive judgment,'" to determine where along that "'rational continuum'" a particular liberty lies. 505 U.S. at 848 (quoting *Poe*, 367 U.S. at 543 (Harlan, J., dissenting)). The more fundamental the liberty interest, the more "careful scrutiny" must be given "the state needs asserted to justify [its] abridgement." *Poe*, 367 U.S. at 543 (Harlan, J., dissenting).

Parenthood v. Casey, 505 U.S. 833, 873-75 (1992); *Poe v. Ullman*, 367 U.S. 497, 548-49 (1961) (Harlan, J., dissenting); *see generally* Note, *Who Decides If There Is "Triumph in the Ultimate Agony?" Constitutional Theory and the Emerging Right To Die with Dignity*, 37 Wm. & Mary L. Rev. 827 (1996) (providing an extended analysis of Justice Harlan's approach as applied to physician-assisted suicide).

As Justice Harlan explained, in assessing whether and to what extent an asserted liberty interest merits constitutional protection, the courts must

> hav[e] regard to what history teaches are the traditions from which [the asserted interest] developed as well as the traditions from which it broke. That tradition is a living thing. A decision of this Court which radically departs from it could not long survive, while a decision which builds on what has survived is likely to be sound.

Id. at 542. It is thus clear that courts are not precluded from recognizing even "an apparently novel claim" of a liberty interest, so long as the claim "depend[s] on grounds which follow from well-accepted principles and criteria." *Id.* at 544. In other words, the newly recognized liberty interest must "take 'its place in relation to what went before and further [cut] a channel for what is to come.'" *Id.* (quoting *Irvine v. California*, 347 U.S. 128, 147 (1954) (Frankfurter, J., dissenting)).

The liberties secured by the Bill of Rights necessarily qualify as "well-accepted principles," *Poe*, 367 U.S. at 543-44 (Harlan, J., dissenting), but the "liberty" embraced by the Fourteenth Amendment is broader than the mere text of those guarantees. "[I]t is the purposes of those guarantees and not their text, the reasons for their statement by the Framers and not the statement itself, . . . which have led to their present status in the compendious notion of 'liberty' embraced in the Fourteenth Amendment." *Id.* at 544 (Harlan, J., dissenting); *see also Palko v. Connecticut*, 302 U.S. 319, 324-27 (1937); *United States v. Carolene Products Co.*, 304 U.S. 144, 152-53 (1938).

As we show below, a terminally ill individual's ability to choose physician-assisted suicide "follow[s] from well-accepted principles and criteria," *Poe*, 367 U.S. at 544 (Harlan, J., dissenting), which derive both from the First Amendment's protection of religious freedom and from the Fourteenth Amendment's proscription of undue government interference in intimate, personal, and spiritual decisions.

A. The Interests Reflected In The Free Exercise Clause And The Liberty Component Of The Due Process Clause Establish That Physician-Assisted Suicide Is A Core Constitutionally Protected Liberty

1. Religious Organizations And Religious Leaders Have Taken A Wide Array Of Positions On The Morality Of Physician-Assisted Suicide

It should be emphasized at the outset that there is "no monolithic 'religious' position on the question of the morality or legality" of assisted suicide. G. Larue, *Playing God — 50 Religions' Views on Your Right to Die* 8 (1996); Campbell, *Religious Ethics and Active Euthanasia in a Pluralistic Society*, 2 Kennedy Inst. of Ethics J. 253, 253-54 (1992).[3] Rather, a "diversity of religious argumentation" exists about whether an individual may morally and ethically choose physician-assisted suicide. Campbell, 2 Kennedy Inst. of Ethics J. at 254.[4] The controversy surrounding physician-assisted suicide is, therefore, not merely "a clash of religious versus secular ethics." *Id.* Indeed, the intense debate over this issue — both among and within religious denominations — underscores that assisted suicide is, for many people, a religious question.[5]

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[3] *See also* Note, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life*, 84 Geo. L.J. 589, 596-601 (1996).

[4] Religious communities are also debating whether the term "suicide" should properly be used to refer to the informed and voluntary decision of a competent, terminally ill individual to hasten death with physician assistance. *See Compassion in Dying v. Washington*, 79 F.3d 790, 808 (9th Cir.) (*en banc*), *cert. granted*, 117 S. Ct. 37 (1996).

[5] Even within religious denominations that institutionally oppose physician-assisted suicide, many of their members may personally hold a different view, which they believe to be consistent with their own religious beliefs. *See* G. Larue, *Playing God — 50 Religions' Views on Your Right to Die* 8 (1996); Campbell, *Religious Ethics and Active Euthanasia in a Pluralistic Society*, 2 Kennedy Inst. of Ethics J. 253, 255-56 (1992) (citing a study finding that 70-80% of those affiliated with

The Roman Catholic Church, to be sure, has been "the sternest, most vigilant, and no doubt most effective opponent of euthanasia." R. Dworkin, *Life's Dominion* 195 (1993). Several other Christian denominations — but by no means all of them — have adopted "official" church positions against the morality of physician-assisted suicide. *See generally* G. Larue, *Euthanasia and Religion: A Survey of the Attitudes of World Religions to the Right-to-Die* 26-117 (1985) (surveying various Christian denominations). Those Christian denominations that oppose physician-assisted suicide do so on two theological grounds: first, that physician-assisted suicide violates the Commandment that "thou shalt not kill," and second, "'that suffering is often sent by God for the remission of sins and the salvation of our souls; so if God has sent someone pain which cannot be alleviated by normal means (pain-killer shots, etc.), we must resign ourselves in the knowledge that this pain is necessary and inevitable.'" *Id.* at 55-56 (quoting Russian Orthodox Archpriest A. Mileant). It is thus acknowledged, even by opponents of physician-assisted suicide, that the suffering of terminally ill people has a spiritual dimension.[6]

These are not the only religious positions, however, on whether the terminally ill may choose to hasten death with physician assistance. The Episcopal Church, for instance, "has not formulated and published any official position on the questions surrounding euthanasia," explaining that to do so would "presuppos[e] a kind of authority of theological teaching and writing which is not relevant in the Episcopal Church." G.

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the major religions supported physician-assisted suicide).

[6] *See* Campbell, 2 Kennedy Inst. of Ethics J. at 268-69 (quoting the Catholic teaching that "'suffering during the last moments of life . . . is in fact a sharing in Christ's passion'"); Episcopal Diocese of Washington, D.C., Committee on Medical Ethics, *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians? Perspectives to Consider* 12-13 (1996) (noting Christian views of the spiritual significance of suffering).

Larue, *Euthanasia and Religion, supra,* at 58 (quotation omitted). *Amicus* Episcopal Diocese of Newark thus appointed a Task Force on Assisted Suicide to study the issue in conjunction with the teachings of the Episcopal Church. The Task Force concluded that physician-assisted suicide "can be theologically and ethically justified" when a terminally ill person makes a voluntary and informed choice after all reasonable means of ameliorating his or her suffering have been exhausted.[7]

The United Church of Christ, the United Methodist Church, and the Presbyterian Church, among others, likewise have not adopted any formal position on physician-assisted suicide. A number of these denominations have taken the position more generally, however, that "basic Christian respect for persons demands that a person's decisions about death be honored in most instances."[8] These denominations encourage their members to offer compassion and understanding — rather than moral absolutes — to terminally ill individuals who are faced with the difficult choice whether to end their own lives.[9] In accordance with this teaching, the Pacific Northwest Conference of the United Methodist Church supported Washington Initiative 119, which would have recognized a right to physician-assisted suicide

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[7] Episcopal Diocese of Newark Task Force on Assisted Suicide, *Report* 9 (1996).

[8] Presbyterian Church (U.S.A.), Christian Faith and Life Area, Congregational Ministries Division, *In Life and Death We Belong to God: Euthanasia, Assisted Suicide, and End-of-Life Issues* 47 (1995) (citing 195th General Assembly position on "The Covenant of Life and the Caring Community" (1983)); *see also* United Church of Christ, The Council for Health and Human Service Ministries, *Making End-of-Life Decisions: United Church of Christ Perspectives* 24 (1993) (supporting "the right and responsibility of individuals to choose their own destiny" as well as "the rights of individuals, their designees and their families to make decisions regarding human death and dying").

[9] *See* United Church of Christ, *Making End-of-Life Decisions* at 24; United Methodist Church, *Book of Resolutions* 144 (1992).

in some circumstances. Campbell, 2 Kennedy Inst. of Ethics J. at 261.

The reformed and humanistic branches of Judaism also teach sympathy, understanding, and respect for those who choose assistance in hastening death. *See* G. Larue, *Playing God, supra,* at 62-65. Some Jewish organizations, including two of the *amici* here, take the position that a competent, terminally ill adult has the right to voluntarily hasten death with the aid of a physician. *See id.* at 64-66; *see also id.* at 56 (reprinting rabbi's statement with respect to Washington Initiative 119 that "[s]ometimes in a medical setting human freedom needs to be exercised resolutely to bring life to an end").

Still other religions have taken more formal institutional positions supporting the right to physician-assisted suicide. The General Assembly of *amicus* Unitarian Universalist Association supports "the right to self-determination in dying, and the release from civil or criminal penalties of those who, under proper safeguards, act to honor the right of terminally ill patients to select the time of their own deaths."[10] *Amicus* Cathar Church, which is Evangelical in doctrine and has some similarity to the Amish and Mennonites, has taught for several centuries that decisions regarding the time and manner of death are matters of individual conscience best left to the individual and his or her God. Many Eastern religions also support a choice of physician-assisted suicide in certain circumstances. *See* Note, *Assisted Suicide and Religion: Conflicting Conceptions of the Sanctity of Human Life,* 84 Geo. L.J. 589, 597 (1996).

As the foregoing discussion demonstrates, the religious community is sharply divided, on theological and ethical grounds, as to the propriety of physician-assisted suicide. This confirms the correctness of this Court's observation in *Cruzan v. Director, Missouri Dep't of Health,* 497 U.S. 261, 277 (1990), that "all

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[10] General Assembly of the Unitarian Universalist Association of Congregations, *The Right to Die with Dignity* (1988).

agree" that an individual's decision to hasten death "is a perplexing question with unusually strong moral and ethical overtones." The Washington and New York statutes, however, dictate only one answer to that "perplexing question" to persons of all religious faiths.

2. A Terminally Ill Person's Decision To Hasten Death Is The Sort Of Personal, Intimate, Often Spiritual Decision To Which The First And Fourteenth Amendments Afford Protection

This Court has recognized in many diverse contexts that each individual should be allowed to define for himself or herself what constitutes a meaningful existence. The Due Process Clause has thus been held to protect "personal decisions relating to marriage, procreation, contraception, family relationships, child rearing, and education." *Casey*, 505 U.S. at 851. Similarly, the First Amendment freedoms have been recognized to occupy a "preferred position in our basic [constitutional] scheme," *Prince v. Massachusetts*, 321 U.S. 158, 164-65 (1944) because "under their shield many types of life, character, opinion and belief can develop unmolested and unobstructed." *Cantwell v. Connecticut*, 310 U.S. 296, 310 (1940).[11] At the heart of individual liberty, therefore, is "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Casey*, 505 U.S. at 851; *see generally Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting) ("The makers of our Constitution . . . recognized the significance of man's spiritual nature . . . [and] knew that only a part of the pain,

[11] *See also Doe v. Bolton*, 410 U.S. 179, 211 (1973) (Douglas, J., concurring) (recognizing the importance of preserving an individual's "autonomous control over the development and expression of one's intellect, interests, tastes, and personality"); Heymann & Barzelay, *The Forest and the Trees:* Roe v. Wade *& Its Critics*, 53 B.U. L. Rev. 765, 773 (1973) (noting "[t]he similarity of the protected rights in the areas of marriage, procreation and child rearing to the expressly protected rights in the areas of religion").

pleasure, and satisfactions of life are to be found in material things.").

A terminally ill person's decision to hasten death is a deeply personal, intimate, and often spiritual one, which is made only after solemn reflection, meditation, or prayer, and after consultation with doctors, family, and clergy.[12] It is a decision that raises "profound issues of human meaning and purpose, of identity and destiny" — issues that "strike to the very core of our being and integrity as persons." Campbell, 2 Kennedy Inst. of Ethics J. at 275; *see Cruzan*, 497 U.S. at 343 (Stevens, J., dissenting) ("[o]ur ethical tradition has long regarded an appreciation of mortality as essential to understanding life's significance"). We frequently turn to religion when we are confronted by these sorts of issues: people "expect from the various religions answers to the riddles of the human condition: . . . What is the meaning and purpose of our lives? . . . What are death, judgment, and retribution after death?" *United States v. Seeger*, 380 U.S. 163, 182 (1965). Indeed, "not much may be said with confidence about death unless it is said from faith." *Cruzan*, 497 U.S. at 343 (Stevens, J., dissenting).

It has thus been recognized that "religion lies at the very heart of" a terminally ill person's decision whether to hasten death. Note, 84 Geo. L.J. at 589.[13] The decision implicates attitudes

[12] *See, e.g.*, Presbyterian Church (U.S.A.), *In Life and Death We Belong to God* at 43 (the decision to commit physician-assisted suicide should be made "thoughtfully and prayerfully, in collaboration with knowledgeable persons not emotionally captured by the situation"); G. Larue, *Euthanasia and Religion: A Survey of The Attitudes of World Religions to the Right-to-Die* 87 (1985) (quoting the United Methodist Church General Council's 1980 statement on Death With Dignity as recognizing the "agonizing personal and moral decisions faced by the dying, their physicians, their families, and their friends").

[13] *See* United Church of Christ, *Making End-of-Life Decisions* at 5 (noting the "intricacies of religious, medical, social, and emotional factors" in each case of terminal illness).

that, for many, are deeply rooted in their religious faith, including attitudes about self-definition, self-determination, and suffering.

Many individuals view their decisions about matters of personal "identity and destiny" as inherently religious ones. As one Protestant religious leader has put it, "the Christ experience is nothing less than our call to be who we are," so "I worship . . . Jesus when I claim my own being and live it out courageously."[14] A number of religious organizations have recognized that dying and death provide terminally ill individuals with a final opportunity to "claim [their] own being," consistent with their own philosophical, ethical, and spiritual attitudes about "human meaning and purpose." *See* Campbell, 2 Kennedy Inst. of Ethics J. at 275 ("our concern about dying well is integral to an understanding of how we might live a rich, meaningful life").[15] For example, "[s]ome persons in terminal conditions long for death as a means of being embraced by the divine," and thus may seek a voluntarily hastened death as a means of "profoundly exercis[ing] their faith when that may be the most meaningful act of creation available to them." G. Larue, *Playing God, supra* at 396 (reprinting report of Greater Seattle Council of Churches). Other terminally ill persons may decide that continuing to exist only with a body racked by pain, or a mind numbed by sedatives, strips them of their personhood. Still others may not want to be remembered in their present condition

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[14] Bishop J.S. Spong, *Rescuing the Bible from Fundamentalism: A Bishop Rethinks the Meaning of Scripture* 242 (1991).

[15] *See* United Church of Christ, *Making End-of-Life Decisions* at 5 (1993) ("The responsibility for life and death is a sacred one, and God calls on us to face up to our freedom of choice."); Episcopal Diocese of Washington, D.C., *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians?* at 21 (noting the view that "Christians have distinctive and compelling reasons for taking these claims of autonomy with great seriousness," because "[w]e are created in the image and likeness of God (Genesis 1: 26-37)" and "[a]n essential part of that image is our ability to make free choices").

"after [their] death by those whose opinions mattered to [them]." *Cruzan*, 497 U.S. at 344 (Stevens, J., dissenting).[16]

There is a spiritual dimension, as well, to individuals' attitudes toward suffering and whether to seek final relief from suffering. With respect to a similarly difficult and intimate issue, this Court observed in *Casey* that the "suffering" endured by a pregnant woman — ranging from "anxieties, to physical constraints, to pain that only she must bear" — is "too intimate and personal for the State to insist" that she continue her pregnancy to term. *Casey*, 505 U.S. at 852. A woman's decision whether to continue or end a pregnancy must, therefore, "be shaped to a large extent on her own conception of her spiritual imperatives." *Id.* The same logic applies to decisions to end one's "suffering" from a terminal illness by hastening one's death; few decisions are more "intimate and personal," and few are more shaped by

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[16] Contrary to the claims of some other religious *amici* (*see, e.g.*, National Catholic Office & Knights of Columbus Br. 4; United States Catholic Conference *et al.* Br. 13-15), physician-assisted suicide may be inextricably intertwined with a terminally ill person's interest in pursuing a meaningful life. The fear of a painful or undignified death may hinder terminally ill individuals from resolving the unsettled aspects of their lives in a meaningful fashion. If such individuals are assured that they may choose the time, place and manner of their death, they are freed to live out their remaining days in a personally meaningful fashion and to come to peace with themselves, with others, and with their God. *See, e.g.*, Quill, Commentary, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 693 (1991) (describing a woman whose fear of a "lingering death" was interfering with her ability to get "the most out of the time she had left"). This is precisely why durable powers of attorney and living wills are recognized and enforced: people benefit in life from knowing that their wishes will be respected at and after death. Stacy, *Death, Privacy, and the Free Exercise of Religion*, 77 Corn. L. Rev. 490, 535 (1992); United Church of Christ, *Making End-of-Life Decisions* at 9 (these devices have "great" benefits: "providing peace of mind for ourselves and our loved ones by making decisions that are in harmony with our faith and our beliefs about stewardship").

an individual's "own conception of [his or] her spiritual imperatives."[17]

The spiritual aspects of suffering differ from one terminally ill individual to another. Some view their suffering as connected with the suffering of Jesus, and thus as a cross that must be borne until God chooses to lift it. *See* Campbell, 2 Kennedy Inst. of Ethics J. at 268-69. For others, however, the suffering and loss of dignity associated with terminal illness is seen *not* as bringing them closer to God, but as distancing them from God. *See* W. Farley, *Tragic Vision and Divine Compassion* 53-59 (1990) (observing that suffering "reduces the capacity of the sufferer to exercise freedom, to feel affection, to hope, to love God").[18] Moreover, as a result of diminished physical capabilities or mental acuity resulting from the illness itself or from pain medications, an individual may lose the ability to pray, to study the teachings of his or her faith, or to interact meaningfully with family, clergy, or members of the religious community. In effect, terminally ill individuals may be forced to exist without their fundamental religious liberties during their final days.

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[17] Some *amici* opposed to physician-assisted suicide have focused on the physically painful nature of terminal illness, which they contend can be treated by proper medication and hospice care. Medication, however, cannot always relieve the pain associated with many terminal illnesses. Moreover, medication can never address an individual's anguish about his or her loss of "personhood," including the loss of physical mobility, mental acuity, emotional connection to other people, and spiritual connection to God. *See* Episcopal Diocese of Washington, D.C., *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians?* at 22; United Church of Christ, *Making End-of-Life Decisions* at 4.

[18] *See also* Episcopal Diocese of Washington, D.C., *Are Assisted Suicide and Euthanasia Morally Acceptable for Christians?* at 22 (noting that suffering "can be destructive of moral and spiritual values and the very dignity with which God has endowed us"); Campbell, 2 Kennedy Inst. of Ethics J. at 269 (suggesting that suffering "presents a threat to the integrity and identity of the self").

Hence, the decision whether to hasten a rapidly impending death will be resolved differently by different individuals, based on their own philosophical, ethical, and religious beliefs. Some will reject physician-assisted suicide as contrary to the teachings of their faith. That decision is, of course, entitled to the utmost respect. Others, however, may conclude that physician-assisted suicide is a morally appropriate choice — perhaps the most morally appropriate choice — in the circumstances according to their understanding of the teachings of their faith. *See, e.g.*, G. Larue, *Playing God, supra,* at 396 (some terminally ill persons view a voluntarily hastened death as a "profoun[d] exercise [of] their faith"); Episcopal Diocese of Newark Task Force on Assisted Suicide, *Report* 9 (1996) (suggesting that there are circumstances in which "involuntary prolonged physical existence is a less ethical alternative than a conscientiously chosen and merciful termination of earthly life").

That decision, too, should be respected by the government. It is a decision that implicates an individual's right under the Free Exercise Clause "to maintain theories of life and of death and of the hereafter." *United States v. Ballard,* 322 U.S. 78, 86 (1944). Just as the Free Exercise Clause protects an individual's right to pursue his or her own understanding of the mysteries of life and death, *see, e.g., id.*, the Due Process Clause should protect an individual's right to make an informed decision whether to continue life in the face of a terminal illness. *See Casey,* 505 U.S. at 851 ("the right to define one's own concept" of, *inter alia*, "the mystery of human life" is "[a]t the heart of liberty"). Like other expressions of belief that emanate from "the kingdom of the individual man and his God," an individual's choice of physician-assisted suicide "should be kept . . . private," not "confounded with what legislatures legitimately may take over into the public domain." *Everson v. Board of Education,* 330 U.S. 1, 57-58 (1947) (Rutledge, J., dissenting).

For these reasons, the Washington and New York statutes are irreconcilable with the motivating spirit of the First and Fourteenth Amendments. Those terminally ill persons whose religions recognize that physician-assisted suicide is an

appropriate ethical and moral choice, or that the determination is best left to the individual's own conscience, are prevented from making this most personal decision in accordance with their "own conception of [their] spiritual imperatives." *Casey*, 505 U.S. at 852.

B. The Interests Reflected In The Establishment Clause Confirm That Physician-Assisted Suicide Is A Core Constitutionally Protected Liberty

The "purposes" and "reasons" underlying the Establishment Clause provide further support for recognizing physician-assisted suicide as a core constitutionally protected liberty under the Due Process Clause. *See Poe*, 367 U.S. at 542 (Harlan, J., dissenting). State bans on physician-assisted suicide are so akin to a government endorsement of religious doctrine as to raise serious Establishment Clause concerns.

At the core of the Establishment Clause is a prohibition on governmental favoritism of a particular religion or of religion generally: "A proper respect for both the Free Exercise and the Establishment Clauses compels the State to . . . favo[r] neither one religion over others nor religious adherents collectively over nonadherents." *Board of Education of Kiryas Joel Village School Dist. v. Grumet*, 114 S. Ct. 2481, 2487 (1994) (citation and internal quotation omitted). This Court has thus carefully scrutinized government action that appears to endorse or reject a religious position, or to compel or coerce support for a religious belief or practice. *See, e.g., Lee v. Weisman*, 505 U.S. 577, 587-88 (1992); *Grand Rapids School Dist. v. Ball*, 473 U.S. 373, 389-90 (1985); *Lynch v. Donnelly*, 465 U.S. 668, 690-94 (1984) (O'Connor, J., concurring). In adopting a view of physician-assisted suicide that is sponsored by, *e.g.*, the Roman Catholic Church, but not accepted by, *e.g.*, the Unitarian Universalist Association, the Washington and New York assisted-suicide bans, in essence, endorse one religious viewpoint to the exclusion of all others. Such endorsement of religious views runs contrary to the "purposes" and "reasons" behind the Establishment Clause.

The statutorily imposed requirement that the terminally ill endure their suffering, rather than terminate it by physician-assisted suicide, conveys an endorsement of the belief, not shared by all religions, that suffering is religiously significant and appropriate. More specifically, the states' efforts to draw a line between "passive" methods of hastening death (which they concede are permissible) and "active" methods (which they argue are impermissible) does nothing less than legalize one religious view and criminalize others.[19] This effectively "prescribe[s] what shall be orthodox" with respect to voluntarily hastened death, and compels the terminally ill "to confess by . . . [the] act [of their continued existence in the face of suffering] their faith therein." *West Virginia Board of Education v. Barnette*, 319 U.S. 624, 642 (1943).

To be sure, this Court has held that statutes do not violate the Establishment Clause simply because they reflect "traditionalist" values. *See Harris v. McRae*, 448 U.S. 297, 319-20 (1980). But bans against assisted suicide are not merely reflections of a "traditionalist" view. To the contrary, laws against suicide stem from the incorporation into the English common law of the canon

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[19] *See, e.g.*, New York Br. 16-18 (attempting to justify New York's ban on physician-assisted suicide by reference to the "difference between action and inaction"); United States Catholic Conference *et al.* Br. 18 n.11 (suggesting that *actively* hastening one's own death is a sin); Union of Orthodox Jewish Congregations & Rabbinical Council Br. 7-8 (interpreting Jewish law as forbidding *active* methods of hastening death but allowing passive methods in some circumstances); Evangelical Lutheran Church Br. 3 (arguing that the distinction between active and passive methods of hastening death is firmly grounded "within the limits of Christian charity"); Brief for the United States and New York Catholic Conferences as *amici curiae* 25 n.63, *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996) (No. 95-7028) (arguing that the "ethical difference between action and inaction "has long been acknowledged by the Christian moral tradition" and that the "refusal of a technique which is already in use . . . is not the equivalent of [the sin of] suicide"). *See generally* Campbell, 2 Kennedy Inst. of Ethics J. at 258-63 (table of "Religious Views on the Right to Die").

law of the Roman Catholic Church. This should cause these bans on assisted suicide to raise Establishment Clause concerns. In this regard, a summary of the origins of suicide laws may be useful to the Court.

"There is nothing in the Old Testament which can clearly be understood as offering explicit judgment on the ancient Judaic view of suicide"; nor is there any "offering in the New Testament to suggest a condemnation of suicide." Neely, *The Right to Self-Directed Death: Reconsidering an Ancient Proscription,* 36 Cath. Law. 111, 121 (1995). In fact, "[i]n the Bible, five people are reported to have ended their own lives (I Samuel 31, II Samuel 17, I Kings 16 and Matthew 27), and the fact of their action is simply reported with no moral judgement implied; at no point is condemnation expressed for their having done so." G. Larue, *Playing God, supra* at 420-22 (quoting Rev. Sallierae Henderson).

Among early Christians, in fact, suicide was not particularly unusual. Because "the supreme duty in this life was to avoid the sin which would result in eternal damnation," the early Christians considered it permissible to commit suicide rather than risk condemnation. Neely, 36 Cath. Law. at 121. Indeed, given that martyrdom at the hands of infidels was an especially prized end, "fanatical Christians" — in particular, a sect known as the Circumcelliones — would invite their own death by "taunt[ing] their Roman persecutors into acts of violence." *Id.* at 122; *see also* G. Williams, *The Sanctity of Life and the Criminal Law* 254-55 (1957); *Compassion in Dying v. Washington,* 79 F.3d 790, 808 (9th Cir.) (*en banc*), *cert. granted,* 117 S. Ct. 37 (1996).

Augustine, who opposed the Circumcelliones' excesses in the name of religion, became "the chief architect" of the Roman Catholic view that suicide is encompassed by the Commandment against killing. G. Williams, *supra* at 255. "St. Augustine argued that committing suicide was a 'detestable and damnable wickedness' and was able to help turn the tide of public opinion" against suicide. *Compassion in Dying,* 79 F.3d at 808 (citing Marzen *et al., Suicide: A Constitutional Right?,* 24 Duq. L. Rev. 1, 27 (1985)). Augustine's views on suicide were eventually

incorporated into the canon law of the Catholic Church. *See* N. St. John-Stevas, *Life, Death and the Law* 233, 249 (1961) (citing 5 A. Neander, *General History of the Christian Religion and Church* 141 (Joseph Torrey trans. 1865)). In the year 673, the Council of Hereford adopted the Roman Catholic canon law, including its prohibition against suicide, into England. *See* G. Williams, *supra* at 257. King Edgar formalized this prohibition in the year 967. *See* Neely, 36 Cath. Law. at 128.

As a result, the prohibition against suicide became part of the common law of England as it emerged around the Twelfth Century. *Id.; see also Compassion in Dying,* 79 F.3d at 845 (Beezer, J., dissenting) ("Between the decline of the Roman Empire and the rise of the Common Law, ecclesiastical law was a dominant force in the English legal order."). One of the first English law treatises, written most likely between 1220 and 1260, explained that suicide was criminalized because of the Augustinian rationale: "In the same way, in which a person may commit a felony by killing another, so he may commit a felony by killing himself, which felony indeed is said to be committed against himself." 2 H. de Bracton, *De Legibus et Consuetudinibus Angliae* 505 (Sir Travers Twiss ed. 1879). Similarly, the Court of King's Bench, writing in 1562, explained the rationale for the legal prohibition on suicide. Central to the court's analysis was the view that suicide was an "offence . . . against God" as well as "against nature" and "against the King." The Court explained that suicide was "against God" because "it is a breach of His commandment, *thou shalt not kill*; and to kill himself, by which act he kills in presumption his own soul, is a greater offence than to kill another." *Hales v. Petit,* 75 Eng. Rep. 387, 400 (1562).[20]

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[20] These three reasons were exactly the same ones articulated by St. Thomas Aquinas in his theological treatise, *Summa Theologica:* "[I]t is altogether unlawful to kill oneself for three reasons . . . [first,] suicide is contrary to the inclination of nature . . . [second,] every man is part of the community . . . by killing himself he injures the community . . . [third,] because life is God's gift to man . . . whoever takes his own

Later English legal scholars echoed the same ecclesiastical underpinnings for the laws against suicide. Sir Matthew Hale explained that the prohibition upon suicide was grounded in principal part upon religious objections: "No man hath the absolute interest of himself but: 1. God almighty hath an interest and propriety in him, and therefore self-murder is a sin against God." I M. Hale, *Historia Placitorum Coronae* *411-12 (1736). Blackstone, too, explicitly recognized that this aspect of the common law was bottomed on "religiou[s]" reasons: "[T]he law of England wisely *and religiously* considers, that no man hath a power to destroy life, but by commission from God." 4 W. Blackstone, *Commentaries* ch. 14, *189 (1765) (emphasis added). Blackstone thus called suicide a "spiritual" "offence," in that the person committing suicide was guilty of "invading the prerogative of the Almighty, and rushing into [H]is immediate presence uncalled for." *Id.*

This reasoning, although an accurate reflection of the long-standing bases for the common law's prohibitions against suicide, is contrary to our American constitutional tradition. In light of our long tradition of religious liberty, arguments that suicide is an "offence . . . against God," which "invade[s] the prerogative of the Almighty," would never be a proper basis for law in this country. Indeed, this Court's Establishment Clause jurisprudence prohibits enactments that have such a religious "purpose." *See, e.g., Epperson v. Arkansas,* 393 U.S. 97, 103 (1968); *Lemon v. Kurtzman,* 403 U.S. at 612-13; *Wallace v. Jaffree,* 472 U.S. 38, 56 (1985); *Edwards v. Aguilard,* 482 U.S. 578, 592-93 (1987).

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Under this Court's prevailing substantive due process analysis — the one articulated by the second Justice Harlan — physician-

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life, sins against God." St. Thomas Aquinas, *Summa Theologica* II-II, q. 64, art. 5 (Fathers of the English Dominican Province eds., vol. 2, pp. 1465 *et seq.*, 1947). *See also Compassion in Dying v. Washington,* 79 F.3d at 845-46 (Beezer, J., dissenting); Marzen *et al., Suicide: A Constitutional Right,* 24 Duq. L. Rev. 1, 29 (1985).

assisted suicide is a core constitutional liberty, which derives both from the specific guarantees (in particular, the religious liberty clauses of the First Amendment) and the generalized aspects of "liberty" protected by the Due Process Clause. A terminally ill individual's decision to hasten death is inextricably intertwined with notions of personhood, identity, and theology; *amici* can imagine few, if any, personal decisions more appropriate to be called a protected "liberty" under the Due Process Clause.

II. THE ASSERTED INTERESTS OF WASHINGTON AND NEW YORK CANNOT JUSTIFY THE TOTAL PROHIBITION UPON THE EXERCISE OF A CORE CONSTITUTIONALLY PROTECTED LIBERTY

As Justice Harlan suggested in *Poe* and as this Court agreed in *Casey*, "certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgement." *Poe,* 367 U.S. at 543 (Harlan, J., dissenting); *Casey*, 505 U.S. at 848-49. In the event that the Court concludes, as *amici* urge in Section I above, that physician-assisted suicide occupies a preferred place on the "rational continuum" of liberty, a "particularly careful scrutiny," *i.e.*, "strict scrutiny," should apply to the Washington and New York bans on assisted suicide. *Casey,* 505 U.S. at 848, 850-51; *Poe,* 367 U.S. at 543 (Harlan, J., dissenting). Strict scrutiny, of course, requires that a statute be the least restrictive means necessary to achieve a compelling governmental interest. Neither statute can withstand this analysis.

First, like the contraception statute at issue in *Poe,* but unlike the abortion statute at issue in *Casey,* these statutes operate as total bans on the asserted liberty interest. Thus, there is no argument available to the states that any lesser standard of scrutiny should apply. *See generally* Dorf, *Incidental Burdens on Fundamental Rights,* 109 Harv. L. Rev. 1176, 1219-32 (1996). As this Court has recognized in *Casey* and in so many other cases, statutes with "incidental effect[s]" on fundamental rights generally pass muster; "undue burden[s]" on fundamental liberty rights are always impermissible under the Due Process Clause. *Casey,* 505 U.S. at 874. The criminalization of assisted suicide

— which constitutes a total ban on that liberty — certainly cannot be categorized as having an "incidental effect" on the liberty right. *See, e.g., Loving v. Virginia,* 388 U.S. 1, 12 (1967) (statute making interracial marriage a felony).

Second, the interests that Washington and New York have proffered in support of their bans on assisted suicide simply do not withstand the "particularly careful scrutiny" mandated by *Casey* and by Justice Harlan's opinion in *Poe*. While the section of Washington's brief purporting to articulate that state's interests in banning assisted suicide (Washington Br. 33-38) is not a model of clarity, the state appears to be asserting two interests: (1) an unqualified interest in the preservation of human life, and (2) "'preventing deaths that occur as a result of errors in medical or legal judgment.'" Washington Br. 33, 34. New York appears to offer essentially the same two interests as justifications for its statute. New York Br. 19-32.

The states' first asserted interest — the preservation of life — is easily dealt with. This Court in *Casey* held that "a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims." *Casey,* 505 U.S. at 857 (citing *Cruzan,* 497 U.S. at 278). The State's interest in preserving life in this case is appropriately seen as less weighty than the interest asserted in *Casey,* where the state's interest (which was "in the protection of *potential* life," 505 U.S. at 871 (emphasis added)) aimed to protect a potential life that was in no position to protect itself. Here, the state laws under consideration purport to protect the lives of competent adults, who are fully capable of protecting their own lives (until the terminal illness runs its course) but who have chosen, for religious and personal reasons, not to do so.[21]

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[21] Moreover, it is questionable whether the states' asserted interest in preserving the life of a terminally ill person who prefers to die can properly be deemed compelling, given that the states have not sought to enforce such an interest with respect to the refusal or termination of medical treatment. *See Church of the Lukumi Babalu Aye, Inc. v. City*

The second interest — preventing error and abuse in decisions regarding death — fares no better. Even assuming that the asserted interest in preventing erroneous or abusive deaths constitutes a "compelling" state interest, neither state has satisfied its burden of establishing that a total ban on physician-assisted suicide is the least restrictive means for achieving that interest. If anything, the risk of error and abuse in physician-assisted suicide is *lower* than it is in other end-of-life decisions that the states *do not* prohibit. With physician-assisted suicide, a competent terminally ill individual is solely responsible for administering the life-ending prescription, and the individual may change his or her mind. The decision is thus voluntary and personal.

By contrast, the discontinuation of treatment according to an advanced directive or to the decision of an appointed surrogate, *cf. Cruzan,* 497 U.S. at 283, carries substantially greater risks of error and abuse, principally because the decision to discontinue treatment, and the discontinuation itself, are not simultaneous events. Yet, both Washington and New York allow this latter means of ending life, with appropriate procedural safeguards — thus confirming that less restrictive means exist for furthering the states' asserted interests in preventing error and abuse. Indeed, *Cruzan* seems already to have established that less-restrictive procedural regulations, such as Missouri's "clear and convincing" standard of proof for the withdrawal of life-sustaining treatment, can satisfy a state's interests, however compelling, in assuring

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of Hialeah, 508 U.S. 520, 547 (1993) ("'a law cannot be regarded as protecting an interest 'of the highest order' . . . when it leaves appreciable damage to that supposedly vital interest unprohibited'") (citations omitted); *Cruzan v. Director, Missouri Dep't of Health*, 497 U.S. 261, 296, 298 (1990) (Scalia, J., concurring) (arguing that the scope of the state's interest in protecting life cannot vary with the means chosen to hasten death).

that a patient is allowed to make "an informed and voluntary choice." *Cruzan*, 497 U.S. at 280.[22]

In sum, the absolute bans on this fundamental liberty are unconstitutionally burdensome; they are far more restrictive than necessary to serve either of the asserted state interests.

CONCLUSION

The judgment of the Court of Appeals for the Second Circuit in No. 95-1858, and the judgment of the Court of Appeals for the Ninth Circuit in No. 96-110, should be affirmed.

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[22] It has also been recognized that any risk that the terminally ill individual is coerced into choosing to hasten death is minimized where the choice is made only after extensive consultation with family, friends, health care professionals, and clergy. *See* R. Westley, *When It's Right to Die: Conflicting Voices, Difficult Choices* 168-69 (1995); *see also* G. Larue, *Playing God*, *supra* at 25-26 (noting the variety of unofficial "countercontrols" that will assure that the decision is informed and voluntary). Moreover, in order to bolster these informal checks on coercion, the states may regulate physician-assisted suicide to assure competency and voluntariness. *Cf. Cruzan*, 497 U.S. at 280.

APPENDIX

APPENDIX

STATEMENTS OF INTEREST OF *AMICI CURIAE*

AMERICANS FOR RELIGIOUS LIBERTY is a nonprofit public interest educational organization dedicated to defending religious liberty, freedom of conscience, and the constitutional principle of separation of church and state. Americans for Religious Liberty has participated as an *amicus* in other cases in this Court that have implicated these concerns. Americans for Religious Liberty believes that bans on physician-assisted suicide conflict with fundamental First Amendment guarantees.

THE AMERICAN HUMANIST ASSOCIATION, founded in 1941, has members and local affiliates throughout the United States. The Association has adopted a formal statement on physician-assisted suicide that recognizes an individual's right to exercise control over the manner and time of dying subject to adequate safeguards assuring that such actions are wholly voluntary and clinically appropriate. Consonant with the principles of autonomy, dignity, and freedom of conscience underlying the First and Fourteenth Amendments, the Association believes that the right to hasten death with the aid of a physician should be protected by this Court.

THE BOARD OF DIRECTORS OF THE SOCIETY FOR HUMANISTIC JUDAISM oversees an organization that reflects the beliefs of approximately one-fifth of the world's Jewish population, and is dedicated to the promotion of Jewish and humanistic ideals, including human dignity, integrity, tolerance, and equal treatment. In view of its respect for the autonomy and dignity of the individual and its compassion for those who are suffering, the Board of Directors believes that a terminally ill person's decision to end his or her suffering should be honored. The Board of Directors thus affirms that competent adults should have the right to make responsible decisions regarding the most profound and private aspects of their own lives — including the choice to hasten death in the face of terminal illness — free from government interference and subject to regulation only to the extent necessary to provide appropriate safeguards.

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Nos. 95-1858 and 96-110

IN THE

Supreme Court Of The United States

OCTOBER TERM, 1996

DENNIS C. VACCO, Attorney General of the State of New York; GEORGE E. PATAKI, Governor of the State of New York; and ROBERT M. MORGENTHAU, District Attorney of New York County,

Petitioners,

v.

TIMOTHY E. QUILL, M.D.; SAMUEL C. KLAGSBRUN, M.D.; and HOWARD A. GROSSMAN, M.D.,

Respondents.

STATE OF WASHINGTON, CHRISTINE O. GREGOIRE, Attorney General of Washington,

Petitioners,

v.

HAROLD GLUCKSBERG, M.D., ABIGAIL HALPERIN, M.D.; THOMAS A. PRESTON, M.D., and PETER SHALIT, M.D., Ph.D.,

Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SECOND CIRCUIT AND FOR THE NINTH CIRCUIT

BRIEF FOR THE NATIONAL WOMEN'S HEALTH NETWORK AND NORTHWEST WOMEN'S LAW CENTER AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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34 pp

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	iii
CONSENT OF PARTIES	1
INTEREST OF *AMICI CURIAE*	1
SUMMARY OF ARGUMENT	2
ARGUMENT	5
I. TRADITIONAL CONCEPTS OF CONSTITUTIONAL LIBERTY PROTECT THE CHOICES OF COMPETENT, TERMINALLY ILL PEOPLE	5
II. AN HISTORICALLY FROZEN CONCEPT OF LIBERTY IS CONTRARY TO THIS COURT'S PRECEDENTS AND POSES A SPECIAL THREAT TO WOMEN	9
III. WOMEN'S EXPERIENCES DEMONSTRATE THAT LIBERTY AND EQUALITY CAN BE THREATENED BY OVERBROAD PROTECTIONIST LEGISLATION	15
IV. THE STATES' CLAIM THAT CRIMINAL SANCTIONS MAY BE IMPOSED TO PROTECT LIFE OVER THE OBJECTION OF THE COMPETENT, TERMINALLY ILL PERSON WHO LIVES IT POSES A SPECIAL THREAT TO WOMEN	23

	Page
V. THE CLAIM THAT THE CONSTITUTION PROHIBITS ONLY LAWS THAT ARE INVALID IN EVERY IMAGINABLE CIRCUMSTANCE IS INCONSISTENT WITH ESTABLISHED SUPREME COURT PRACTICE	25
CONCLUSION	29

TABLE OF AUTHORITIES

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Bowers v. Hardwick, 478 U.S. 186 (1986)	9, 10
Bradwell v. Illinois, 83 U.S. (16 Wall.) 130 (1872)	17
Buck v. Bell, 274 U.S. 200 (1927)	18
Carey v. Population Services International, 431 U.S. 678 (1977)	8
Compassion in Dying v. Washington, 49 F.3d 586, *rev'd* 80 F.3d 716 (9th Cir. 1996)	10, 25
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Compassion in Dying v. Washington, 850 F. Supp. 1464 (D. Wash. 1994)	20, 21
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Eisenstadt v. Baird, 405 U.S. 438 (1972)	8, 15
Griswold v. Connecticut, 381 U.S. 479 (1965)	*passim*
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Janklow v. Planned Parenthood, Sioux Falls Clinic, 116 S. Ct. 1582 (1996)	28
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Meyer v. Nebraska, 262 U.S. 390 (1923)	7
Michael H. v. Gerald D., 491 U.S. 110 (1989)	9
Moore v. City of East Cleveland, 431 U.S. 494 (1977)	8, 15
National Mut. Ins. Co. v. Tidewater Transfer Co., 337 U.S. 582 (1949)	12
Orr v. Orr, 440 U.S. 268 (1991)	12
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Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 (1992)	*passim*
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Quill v. Vacco, 80 F.3d 716 (1996)	10, 26
Relf v. Weinberger, 372 F. Supp. 1196 (D.D.C. 1974), *vacated by* 565 F.2d 722 (D.C. Cir. 1977)	18
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Roe v. Wade, 410 U.S. 113 (1973)	*passim*

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Skinner v. Oklahoma, 316 U.S. 535 (1942)	18
Twin City Bank v. Nebeker, 167 U.S. 196 (1897)	28
United States v. Salerno, 481 U.S. 739 (1987)	25, 26, 28
United States v. Virginia, 116 S.Ct 2264 (1996)	11
Webster v. Reproductive Health Services, 492 U.S. 490 (1989)	13
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Herma Hill Kay, *Models of Equality*, 1985 U. Ill. L. Rev. 39	14
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Kevorkian Faces New Charges, Reuters, Ltd., Oct. 31, 1996	21, 22
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CONSENT OF THE PARTIES

All Petitioners and Respondents in both *State of Washington, et al. v. Glucksberg, et. al.*, No. 96-110, and *Vacco, et al. v. Quill, et. al.*, No. 95-1858, have consented to the filing of this brief. Their letters of consent are being filed herewith.

INTEREST OF *AMICI CURIAE*

Amicus National Women's Health Network (the "Network") is the only national public-interest membership organization devoted solely to women and health. Founded in 1974, the Network has influenced national policy as a women's voice dedicated to humane, responsive health care. *Amicus* Northwest Women's Law Center ("NWLC") is a non-profit public interest organization dedicated to advancing the legal rights of women through litigation, legislative advocacy, education and an information and referral telephone service. Since its founding in 1978, the NWLC has been dedicated to protecting the fundamental rights to liberty, privacy, autonomy and bodily integrity. The NWLC has participated in litigation opposing a variety of state restrictions on individual liberty in the context of abortion and reproductive freedom.

Amici, women's rights organizations and advocates, explain why these cases raise constitutional issues of special importance to women. Although the criminal statutes challenged here do not use gender-based classifications, and the fundamental liberty interest at stake here is of vital concern to all people, women's perspectives on this Court's fundamental liberty jurisprudence are distinctive because the law and the Constitution have treated men and women as different. Much of that jurisprudence has been developed in the context of state legislative restrictions on contraception and abortion, matters of special interest to women. This brief discusses how the treatment of women under our Constitution and laws supports the claims advanced by the Respondents in these cases.

SUMMARY OF ARGUMENT

These cases require the Court to resolve whether terminally ill people have a constitutionally protected interest in controlling the circumstances of their death and whether that interest is violated by an absolute and uncompromising ban on physician assistance. *Amici* urge the Court to affirm the decisions of the Ninth Circuit, *en banc*, and the Second Circuit holding that terminally ill individuals have a constitutionally protected liberty interest in controlling the circumstances of their deaths. That liberty interest precludes states from enacting blanket criminal prohibitions on doctors who facilitate the choices of competent, terminally ill patients who seek to hasten death. The experience of women under the Constitution and laws supports this Court's protection of such fundamental and basic personal rights of liberty and choice.

This Court's precedents recognize a principled and cohesive concept of liberty that guards against unwarranted state interference with highly intimate, personal choices—those that are central to dignity and autonomy—including choices relating to marriage, childbirth, family relations and death. Although the constitutional protection of fundamental liberty is vital to all people, many of the situations in which this Court has protected fundamental liberty against state inference are of particular importance to women. Under this Court's ordered and principled conception of fundamental liberty, the choice of a terminally ill person about the circumstances of his or her death must be protected against blanket state prohibition on physician assistance.

In order to reverse the decisions below, Petitioners the State of Washington and the State of New York (the "States") and many of the *amici* who support their position suggest that the Constitution protects only those rights specifically recognized when the Constitution or the Fourteenth Amendment was adopted. This wooden, historically frozen

concept of constitutionally protected liberty poses a particular threat to women (among other historically oppressed populations) because, both in 1789 and in 1868, our Constitution and laws pervasively and explicitly denied women personal, civil and political rights. Although history and tradition can serve as useful guides in the interpretative process, the Constitution's guarantee of liberty ultimately must be interpreted in a principled manner that acknowledges a cohesive and evolutionary concept of liberty and that is sensitive to the social inequalities imbedded in our history and traditions.

The States contend that even if the laws at issue here implicate a fundamental liberty interest, they nonetheless pass constitutional muster. This Court has long held that a state law that burdens the exercise of fundamental liberties must be carefully tailored to serve important state interests. The States offer two core justifications for their absolute criminal ban on physician assisted suicide: first, the desire to protect vulnerable people from coercion by banning even the authentic and informed choices of terminally ill people; and second, the desire to promote respect for life, regardless of the circumstances or conscientious choices of the person who is living it. Both of these purposes asserted by the States (or closely analogous purposes) have historically been utilized in ways that have been particularly damaging to women.

The States' blanket ban on physician assisted suicide does not protect individual choice from coercion, but instead prohibits Respondents from freely choosing to exercise a fundamental liberty. A state may act to prevent coercion, to assure authentic choice, to encourage the medical profession to do a better job of treating pain and depression, and to address a wide range of legitimate state concerns about the welfare of its people. But it must do so by enacting properly tailored laws that safeguard the rights of all individuals to exercise their fundamental liberties, which include the right

of a terminally ill person to choose freely (with the advice of a doctor and in accordance with his or her conscience) whether to hasten death. Women's experience under the laws and Constitution—and particularly the experience of women prior to this Court's recognition that the Constitution protects individual choice over procreation—illustrates that people are injured, the quality of their lives diminished and their humanity denied when the law prohibits free and authentic choice about important life decisions.

The States' assertion of an absolute and overriding interest in protecting life, irrespective of the circumstances, has been squarely rejected by this Court. That interest has been most often asserted to defend laws that deny women their fundamental liberty to choose abortion. Women's experience in seeking legal and constitutional protection for reproductive choice counsels an imperative need for careful scrutiny of state efforts to use the criminal law to mandate the perpetuation of life over all competing interests, including such valid and compelling interests as the desires, needs and indeed fundamental rights of the person who must live that life.

Finally, in the courts below, the States urged a rule of constitutional interpretation that would dictate that a law that is challenged as violating a fundamental constitutional right may not be held unconstitutional unless it is invalid in every conceivable situation to which it might apply. This rule has no application to these cases, because Respondents challenge the laws at issue here as applied only to them and similarly situated people. Indeed, the States do not argue that this is an appropriate case for this Court to apply the rule they urged below. Moreover, even if applicable to these cases, the rule is inconsistent with the principles and practices of the last two centuries and would threaten all constitutionally protected liberties, including those that are particularly important to women.

ARGUMENT

I. TRADITIONAL CONCEPTS OF CONSTITUTIONAL LIBERTY PROTECT THE CHOICES OF COMPETENT, TERMINALLY ILL PEOPLE.

The liberty interest asserted by the Respondents in these cases encompasses several elements. Competent people who are confronted with imminent death because of terminal illness no longer enjoy many of the most significant aspects of life and choice. For Respondents then, the most meaningful liberty left available to them is the ability to control the circumstances of death. Justice Stevens eloquently described this interest in *Cruzan v. Missouri Dep't of Health*:

> "Choices about death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental' . . . .
>
> The more precise constitutional significance of death is difficult to describe; not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience. We may also, however, justly assume that death is not life's simple opposite, or its necessary terminus, but rather its completion. Our ethical tradition has long regarded an appreciation of mortality as essential to understanding life's significance. It may, in fact, be impossible to live for anything without being prepared to die for something."

497 U.S. 261, 343 (1990) (Stevens, J., dissenting) (citations omitted).[1] As Justice Stevens recognized, the power of the terminally-ill to choose the circumstances and timing of death is fundamental, however that choice is exercised.

Decisions regarding the circumstances and timing of one's death also implicate rights of intimate association. No state currently prohibits suicide, but many terminally ill patients who would choose to die in a private, dignified, non-violent and effective manner that requires physician assistance are prohibited from doing so by the statutes at issue here. A criminal ban on physician assistance to the terminally-ill forces those individuals to act alone and prevents them from seeking the support and comfort of their physicians and their loved ones. When suicide is allowed, but help in dying is prohibited, the terminally-ill person is left to die alone and often with prolonged pain.[2] Thus, the state denies the

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[1] Although Justice Stevens articulated this principle in a dissent, the Court did not disagree with his formulation of the liberty interest at state. Rather, the Court split over whether a state could impose a heightened evidentiary standard before a terminally ill patient could exercise that liberty interest by terminating a life support system. *See infra* note 24.

[2] Respondent Dr. Timothy Quill offers this reflection on the death of Diane, the long-term patient to whom he had provided barbiturates:

> "I did not want her to have to face this final moment alone. Had she asked me to be with her, and had I complied, the legal risk of my participation would have increased substantially. She died alone as a final altruistic act to protect both her family and me from potential prosecution. She researched the law in the state of New York and rightly discovered that the legal risk of the assisters increases dramatically if they are present at the time of death."

Timothy E. Quill, *The Ambiguity of Clinical Intentions*, 329 New Eng. J. Med. 1039, 1040 (1993).

Different terminally ill people make different choices. Andrew Solomon describes his mother, who went through months of aggressive treatment for cancer. She said:

> "As long as there is even a remote chance of my getting well, I'll go on with treatments. When they say that they are keeping me alive but without any chance of recovery, then I'll stop."

Andrew Solomon, *A Death of One's Own*, The New Yorker, May 22, 1995, at 58. At the end,

> "[she] considered doing the whole thing on her own but had thought that the shock would be worse than the memories of having been with her for the experience. As for us, we wanted to be there. My mother's life was in other people, and we all hated the idea of her dying alone."

Id. at 64.

terminally-ill profoundly important rights of intimate association.

The interest that Respondents assert is well rooted in this Court's precedents. Throughout our history, this Court has interpreted the Constitution to protect basic individual rights of personal liberty, choice and intimate association.[3] In *Griswold v. Connecticut*, the Court held that the liberty protected by the Constitution encompasses married people's right to use contraceptives and look to their physicians to help obtain them. 381 U.S. 479 (1965). This Court has recognized that "[t]he full scope of the liberty guaranteed by the Due Process Clause . . . is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints".[4] *Griswold* offers a principled and reasoned approach to defining liberty, an approach which is in the mainstream of this Court's precedents.[5] A dying person's interest in controlling the

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[3] *See, e.g., Meyer v. Nebraska*, 262 U.S. 390 (1923) (striking a law that prohibited parents from teaching their children in a language other than English); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925) (striking a law that required parents to send their children to public school).

[4] *Poe v. Ullman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds of an earlier challenge to the Connecticut ban on birth control).

[5] *See, e.g., Roe v. Wade*, 410 U.S. 113 (1973); *Cruzan v. Missouri Dep't. of Health*, 497 U.S. 261 (1990); *Planned Parenthood of*

circumstances and timing of his or her own death falls squarely within the "rational continuum" of liberty recognized in *Griswold*.[6]

Women have a special interest in preserving and developing the protection of liberty recognized in *Griswold*. Despite the fact that a law denying married people access to contraception impacts married men as well as married women, as a practical matter, married peoples' inability to control fertility hurts women more than it does men.[7] Many of the other contexts in which the Court has found that state laws violate individual liberty also present issues of particular importance to women.[8] This Court should not retreat from the principled approach to liberty recognized in *Griswold*, because the freedom and autonomy of women and other historically oppressed groups depend so heavily on the fundamental liberties that this Court has historically protected.

Southeastern Pa. v. Casey, 505 U.S. 833 (1992).

[6] *See Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) ("the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water"); *Compassion in Dying v. Washington*, 79 F.3d 790, 803-806 (9th Cir. 1996) (*en banc*).

[7] Women are not the only group specially impacted by the liberty interest recognized in *Griswold*. Prior to *Griswold*, in Connecticut, educated married couples who had money obtained and used contraceptives, and the burden of the criminal prohibition fell on the uneducated and the poor. *See* David J. Garrow, *Liberty and Sexuality: The Right to Privacy and the Making of* Roe v. Wade 197 (1994).

[8] *See, e.g., Carey v. Population Services International*, 431 U.S. 678 (1977) (recognizing minor's right to purchase non-prescription contraceptives without parental consent); *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (recognizing right of family members to live together); *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (recognizing unmarried people's right to obtain contraceptives).

The Solicitor General seeks to trivialize Respondents' claims that the criminal bans challenged here violate fundamental rights to choice, autonomy, dignity, privacy and intimate association by narrowing the claimed interest to a desire to "avoiding severe pain or suffering".[9] For Respondents and the physicians who serve them, the power to choose the circumstances and timing of their death involves far more than simply avoiding pain or suffering. It involves an act of self-assertion and self-control over the only thing they can control. It involves the ability to end their lives in a dignified, painless manner in the presence of their physicians and loved ones. In short, Respondents' claim to choice implicates "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy". *Casey*, 505 U.S. at 851.

II. AN HISTORICALLY FROZEN CONCEPT OF LIBERTY IS CONTRARY TO THIS COURT'S PRECEDENTS AND POSES A SPECIAL THREAT TO WOMEN.

In recent years, an alternative approach to the definition of constitutionally protected liberty has been offered. That approach resolves claims to constitutional liberty by reference "to the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified".[10] The States, and the lower court judges who

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[9] Brief for the United States as *Amicus Curiae*, in No. 96-110 ("United States Br.") at 16.

[10] *Michael H. v. Gerald D.*, 491 U.S. 110, 128 n.6 (1989) (Scalia, J.) (citing in part *Bowers v. Hardwick*, 478 U.S. 186 (1986)) (denying a biological father the right to visit with his daughter, with whom he had an established relationship, because the mother subsequently married another man). Chief Justice Rehnquist joined this opinion. Justice O'Connor concurred "in all but footnote 6 of Justice Scalia's opinion". *Id.* at 132. Justice Kennedy joined Justice O'Connor's concurrence. Justice Stevens concurred in the judgment. Justices Brennan, Marshall, Blackmun

would deny Respondents' assertion of constitutionally protected liberty, rely primarily on this alternative jurisprudence, arguing that the Constitution protects only those liberty interests that were specifically protected in our Nation's history and tradition.[11] Such a wooden historical approach to constitutional jurisprudence is at odds with this Court's precedents and is particularly threatening to women.

This Court's precedents demonstrate an unwillingness to freeze the right to be free from arbitrary government interference within a static tradition or history. Notions of fundamental liberty and privacy have evolved continuously as our society has changed. Indeed, Justice Harlan stated over 30 years ago that the concept of liberty embodied in this Court's precedents has never "been reduced to any formula"

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and White dissented.

[11] The States and many of the *amici* who support their position read this Court's decision in *Bowers v. Hardwick*, 478 U.S. 186 (1986), as supporting an historically frozen concept of constitutionally protected liberty. *See, e.g.*, Brief for the Petitioner, in No. 96-110 ("Washington Br.") at 21-25 (arguing fundamental liberty must be "'deeply rooted in this nation's history and tradition'") (citing *Bowers*, 478 U.S. at 191-92); Brief *Amici Curiae* of The Legal Center for Defense of Life, Inc. and The Pro-Life Legal Defense Fund at 3-4. In rejecting Respondents' liberty claims, the Second Circuit considered itself bound by the States' reading of *Bowers*, and observed that "[its] position in the judicial hierarchy constrains [it] to be even more reluctant than the Court to undertake an expansive approach in this unchartered area". *Quill v. Vacco*, 80 F.3d 716, 725 (2d Cir. 1996). Similarly, the judges who dissented from the Ninth Circuit's *en banc* decision in favor of Respondents relied heavily on their perception of this Court's "unwillingness" to find new fundamental rights. *Compassion in Dying v. Washington*, 79 F.3d 790, 848 (9th Cir. 1996) (*en banc*) (Beezer, J., dissenting); *see also Compassion in Dying v. Washington*, 49 F.3d 586, 591 (9th Cir. 1995) (Noonan, J.) (refusing to "invent" a constitutional right that did not previously exist), *rev'd* 79 F.3d 790 (9th Cir. 1996) (*en banc*).

nor "determined by reference to any code".[12] The Court has continued to affirm that the constitutional protection of fundamental liberties cannot be limited by a static reading of history and tradition: "Neither the Bill of Rights nor the specific practices of the States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects". *Casey*, 505 U.S. at 848.

The formalistic definition of liberty urged by the States would have a particularly detrimental impact on women. It would freeze for all time the social inequalities suffered currently by women and eliminate all chances for judicial or constitutional facilitation of the achievement of gender equality. It would allow a state to enact legislation that reinforced "its own vision of the woman's role" anywhere that vision can be found to be rooted in "our history and our culture". *Casey*, 505 U.S. at 852. As Justice Ginsburg recently reminded us, "'our Nation has had a long and unfortunate history of sex discrimination'". *United States v. Virginia*, 116 S. Ct. 2264, 2274-75 (1996) (citation omitted). At the time of the adoption of the Fourteenth Amendment, married women were deemed not to exist in the eyes of the law: they were not allowed to hold property, to contract, or to vote. Moreover, until the latter half of this century, the law explicitly sought to "perpetuate the legal, social, and economic inferiority of women". *Id* at 2276. The Constitution's basic guarantee of "liberty" must be interpreted

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[12] *Poe*, 367 U.S. at 542 (Harlan, J., dissenting); *see also Rochin v. California*, 342 U.S. 165, 169 (1952) (Frankfurter, J.) ("In dealing not with the machinery of government but with human rights, the absence of formal exactitude or want of fixity of meaning, is not an unusual or even regrettable attribute of constitutional provisions").

to prevent and redress such historical inequities, not to *reinforce* them.[13]

This Court has refused to embrace an historical definition of liberty that traps us in a stagnant society and abandons marginalized groups and unconventional life choices to oppressive government regulation.[14] *Griswold* raised such issues. Although the general "public opinion . . . of a bygone day" condemned the use of contraceptives, *Poe*, 367 U.S. at 546-57 n.12 (Frankfurter, J.), this Court correctly held that the Constitution protects a married person's right to obtain contraceptives. Likewise, this Court recognized in *Casey* that "interracial marriage was illegal in most States in the 19th century, but the Court was no doubt correct in finding it to be an aspect of liberty protected against state interference by the substantive component of the Due Process clause in *Loving v. Virginia*, [388 U.S. 1 (1967)]". 505 U.S. at 848. Indeed, in *Casey*, this Court expressly refused to interpret the Constitution by reference to an historical tradition that placed women at the "center of home and family" because that tradition is "no longer consistent with our understanding of the family, the individual, or the Constitution". 505 U.S. at 897.[15]

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[13] *See, e.g., Palmore v. Sidoti*, 466 U.S. 429, 433 (1984) (holding mother's marriage to an African-American does not justify changing custody to father; "[p]rivate biases may be outside the reach of the law, but the law cannot, directly or indirectly, give them effect"); *Orr v. Orr*, 440 U.S. 268 (1971) (state may not require that husbands, but not wives, pay alimony).

[14] *See National Mut. Ins. Co. v. Tidewater Transfer Co.*, 337 U.S. 582, 646 (1949) (Frankfurter, J., dissenting) ("Great concepts like . . . 'liberty,' . . . were purposely left to gather meaning from experience [,] [f]or . . . only a stagnant society remains unchanged.") (citations omitted).

[15] As the Ninth Circuit held, "if historical evidence of accepted practices at the time the Fourteenth Amendment was enacted were dispositive, this Court would not only have decided *Loving* differently, but it would not have held that women have a right to an abortion". 79 F.3d at 806.

The Solicitor General implicitly recognizes that a concept of constitutionally protected liberty frozen in 1868 is inconsistent with well established principles, and that it threatens all people whose equality and liberty were historically and wrongfully denied under our Constitution and laws.[16] Nonetheless, the Solicitor General offers a frozen and artificial concept of liberty: the Solicitor General suggests that the Court should recognize the liberties that had been deemed by this Court to be protected by the Constitution up through 1992, with the Court's decision in *Casey*, but go no further. According to the Solicitor General, then, a bench mark date of 1868, when equal protection and liberty were blatantly and pervasively denied to women and others would be wrong, but adopting a random but pleasing (in that it stops short of recognizing the right to determine the time and manner of death) benchmark date of 1992 is appropriate. This formulation is as flawed and inflexible as the States' interpretation, and for the same reasons.

This Solicitor General's predecessor, Charles Fried, offered a similar argument in 1989, urging that the Court overrule *Roe*, but retain *Griswold*.[17] The Court has rejected that argument and reaffirmed that "'liberty' is not a series of isolated points . . . [Rather i]t is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints . . . and which

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[16] United States Br. at 16-18.

[17] Specifically, in oral argument in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989), Solicitor General Fried argued: "The government is not asking the Court to unravel the fabric of privacy rights but rather just to pull this one thread". Frank Susman, the lawyer for the women, responded that in his experience "when someone pulls a thread, the sleeve falls off." *See* Supreme Court Proceedings, Argument Before the Court, 57 U.S.L.W. 3715 (May 2, 1989).

also recognizes, what a reasonable and sensitive judgment must, that certain interests require particularly careful scrutiny of the state needs asserted to justify their abridgment."[18] This Court should likewise reject the current Solicitor General's attempt to freeze the development of our concept of fundamental liberty in 1992.

Apparently appreciating the grave threat that the States' anemic concept of liberty poses to women, the Solicitor General suggests that concepts of gender equality will suffice to protect certain rights of particular concern to women (like abortion) that have historically been protected as an aspect of fundamental liberty under our Constitution.[19] Many scholars have advanced gender equality arguments in support of fundamental liberty interests in reproductive choice.[20] *Amici*

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[18] *Casey*, 505 U.S. at 848-49 (quoting *Poe*, 367 U.S. at 543 (Harlan, J., dissenting)) (internal quotations omitted).

[19] The Solicitor General quotes a law review article critique of physician assisted suicide that states: "'Requiring women to bear unwanted children threatens to lock them into a traditional and subordinate role, embodies assumptions about their inability to make autonomous moral choices, and burdens women as a group with obligations that have no counterpart in the burdens that the State demands from men'". United States Br. at 17 (citing Seth F. Kreimer, *Does Pro-Choice Mean Pro-Kevorkian? An Essay On Roe, Casey, And The Right To Die*, 44 Am. U.L. Rev. 803, 849 (1995)).

[20] *See, e.g.*, Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. Rev. 375 (1985); Kenneth Karst, *The Supreme Court, 1976 Term - Forward: Equal Citizenship Under the Fourteenth Amendment*, 91 Harv. L. Rev. 1, 53-59 (1977); Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. Pa. L. Rev. 955 (1984); Herma Hill Kay, *Models of Equality*, 1985 U. Ill. L. Rev. 39; Katharine A. MacKinnon, *Reflections on Sex Equality under Law*, 100 Yale L. J. 1281 (1991); Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 Stan L. Rev. 261 (1992); Laurence H. Tribe, *Abortion: The Clash of Absolutes* 105 (1992).

support a concept of gender equality that encompasses concern with protection of fundamental rights of reproductive choice and will applaud judicial development of constitutional principles that recognize that reproductive choice encompasses issues of both gender equality and fundamental liberty. As the Court recognized in *Casey*, "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives". 505 U.S. at 856.[21] Nonetheless, women have learned that their ability to participate fully in society depends on this Court's recognition of a principled and cohesive concept of liberty that embraces a wide range of highly intimate and personal decisions.[22] This Court should not retreat from its precedents recognizing such fundamental liberties in favor of a frozen and wooden concept of liberty merely because certain rights that are important to women may continue to be protected as a matter of gender equality.

III. WOMEN'S EXPERIENCES DEMONSTRATE THAT LIBERTY AND EQUALITY ARE THREATENED BY OVERBROAD PROTECTIONIST LEGISLATION.

The central argument offered to support imposing criminal sanctions on doctors who assist terminally ill patients to exercise their constitutional rights in the face of death is that

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[21] *See also id.* at 852 ("[a pregnant woman's] suffering is too intimate and personal for the State to insist, without more, upon its own vision of the women's role, however dominant that vision has been in the course of our history and our culture").

[22] As shown above, cases such as *Griswold*, *Eisenstadt*, and *Moore*, which are at the heart of this Court's historic commitment to the protection of a principled and cohesive concept of liberty, have been particularly important to women. Those cases recognize a liberty interest that is enjoyed by both men and women, but that, as a practical matter, is more important to women because of the inequities suffered by women. *See supra* at 7-8.

the ban is necessary to protect certain vulnerable people.[23] As the debate among the Justices in *Cruzan* underscores, the question of how best to protect authentic individual choice where the individual whose life is at stake cannot make his or her own decisions is a complex matter.[24] The present cases, however, do not present these complex issues. Respondents here are competent, terminally ill people who have made the choice to die with as much dignity as possible, with the assistance and comfort of their physicians. Respondents' decisions are clear. Although the States may act to protect informed and authentic choice, they cannot override the fundamental right of the terminally-ill to choose the circumstances of their death merely because they want to protect others who would make different choices. And the States cannot *prevent* the terminally-ill from choosing to

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[23] Washington Br. at 33-38; Brief for the Petitioners, in 95-1858 ("New York Br.") at 27-32; United States Br. at 19-32.

[24] In *Cruzan*, this Court accepted the principle that a terminally ill patient has a constitutional right to discontinue life-sustaining treatment, including a forced feeding apparatus. The Court split over whether a state could demand that the guardians of a patient in a persistent vegetative state demonstrate the patient's wishes by "clear and convincing" evidence to terminate treatment. *See* 497 U.S. at 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality. We believe Missouri may legitimately seek to safeguard the personal element of this choice through the imposition of heightened evidentiary requirements."); *id.* at 316 (Brennan, J., dissenting) ("Missouri may constitutionally impose only those procedural requirements that serve to enhance the accuracy of a determination of Nancy Cruzan's wishes or are at least consistent with an accurate determination. The Missouri 'safeguard' that the Court upholds today does not meet that standard."); *cf. Casey*, 505 U.S. at 872 ("[t]hough the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed").

hasten their own deaths because the States disagree with and disapprove of their decisions to choose to die.[25]

The States argue, at bottom, that Respondents' fundamental liberty can be sacrificed as a necessary cost of protecting others: "individual cases cannot establish the foundation of a policy which would have such serious and widespread repercussions . . . . The interest of the individual cannot be separated from the interests of society as a whole".[26] The notion that "the rules of civil society must be adapted to the general constitution of things, and cannot be based upon exceptional cases,"[27] has been used historically to maintain the inequality of women under the law. In *Bradwell v. Illinois*, the Court invoked the presumed interests of society as a whole and the general social good to justify denying a qualified woman the right to practice law. *Id.* There the assumption was that Myra Bradwell was different from most women *and* that her own competence was irrelevant because allowing her to practice law would undermine general social expectations about the appropriate roles of men and women. Similarly here, the States argue that the interests of society as a whole justify denying Respondents' fundamental liberty because Respondents are presumed to be atypical.

Although a flat ban prohibiting doctors from helping competent, terminally ill people to exercise control over the circumstances of their deaths is unconstitutional, states are not

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[25] *See Hodgson v. Minnesota*, 497 U.S. 417, 435 (1990) ("[T]he regulation of constitutionally protected decisions . . . must be predicated on legitimate state concerns other than disagreement with the choice the individual has made . . . . Otherwise, the interest in liberty protected by the Due Process Clause would be a nullity.").

[26] New York Br. at 21; *see also* Washington Br. at 40.

[27] *Bradwell v. Illinois*, 83 U.S. (16 Wall.) 130, 141-142 (1872) (Bradley, J., concurring).

powerless to regulate in this arena. Where abuse is likely, states may act to insure voluntary and informed choices that are free from coercion. By requiring doctors to treat their patients' pain and depression, and requiring that patients be provided with information about alternatives, states may safeguard against abuse without unnecessarily and impermissibly infringing on the liberty of those who choose to die. Indeed, prominent physicians, attorneys, and other professionals have offered model regulations that would achieve the States' legitimate goals of protecting against involuntary and accidental death far more effectively than the current absolute bans.[28] Oregon's Death with Dignity Act provides another model,[29] as do the standards developed by the Respondent physicians in this case.[30] Women have often suffered coercion and abuse at the hands of the medical profession in relation to pregnancy and birth control.[31] As such, women have a keen appreciation for the ways in which narrowly tailored regulation of physicians can provide protection against malfeasance and abuse. A prohibition on choice like the ones at issue here, however, will not achieve that objective.

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[28] *See, e.g.*, F. G. Miller, et al., *Regulating Physician Assisted Death*, 331 N. Eng. J. Med. 119 (1994); Charles H. Baron, et al., *A Model State Act to Authorize and Regulate Physician-Assisted Suicide*, 33 Harv. J. on Legis. 1 (1996).

[29] 1995 Or. Rev. Stat. § 127.800 et seq.

[30] *See infra* note 36.

[31] *See, In Re A.C.*, 573 A.2d 1235 (D.C. Ct. of App. 1990) (holding that cesarian section provided against the wishes of a competent woman violated her common law rights); *Buck v. Bell*, 274 U.S. 200 (1927) (approving compulsory eugenic sterilization and implicitly overruled by *Skinner v. Oklahoma*, 316 U.S. 535 (1942)); *Relf v. Weinberger*, 372 F. Supp. 1196, 1199 (D.D. C. 1974) (discussing coerced consent to sterilization and government efforts to prevent it in the context of the Medicaid program), *vacated by* 565 F.2d 722 (D.C. Cir. 1977).

Women's experience under the Constitution and laws of the United States evidences the dangers inherent in such overbroad, "protectionist" policies. Consider the history of the regulation of abortion in this country. The 19th century laws criminalizing abortion were adopted at the urging of the medical profession, in significant part because of a desire to "protect" women from the dangers of abortions provided by unskilled practitioners.[32] Criminal bans against abortion, however, did not prevent people from seeking or performing abortions.[33] The ban served to make the procedure more costly, more humiliating, more dangerous and often deadly.[34]

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[32] *Roe v. Wade*, 410 U.S. 113, 148-49 (1973) ("When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman . . . . Antiseptic techniques . . . were often not generally accepted and employed until about the turn of the century. Abortion mortality was high."); *see also* James Mohr, *Abortion in America: The Origins and Evolution of National Policy* 21-22, 31-32, 37 (1978).

[33] Regina Stix & Dorothy Wiehl, *Abortion and Public Health*, 28 Am J. Pub. Health 622, Table I (1938) (noting that the incidence of abortion ranged from one pregnancy in seven at the turn of the century to one in three in 1936). The Kinsey Report found that in the 1950s between one in five and one in four women who had ever been married had aborted a pregnancy. Almost 90 percent of the premarital pregnancies reported in that study were ended by abortions, most of them illegal. Paul Gebbard et al., *Pregnancy, Birth, and Abortion* 93-94, 54 (1958). In the 1950s, researchers estimated that between 200,000 and one million U.S. women had illegal abortions each year. *Abortion in the United States* 178-80 (Mary S. Calderone ed., 1958).

[34] Most illegal abortions were performed "under unsafe—usually degrading—conditions". Frederick S. Jaffe, Barbara L. Lindheim & Philip R. Lee, *Abortion Politics: Private Morality and Public Policy* 22 (1981). Illegal abortionists apprehended in the 1960s following the deaths of women "included a boat-yard worker, a real-estate salesman, a hospital orderly, and an automotive mechanic. These operators often worked under unsanitary conditions and avoided anesthesia, so they could speed women who had just been aborted on their way." *Id.* In 1961, the Center for Disease Control identified 320 deaths from complications of illegal

It also spawned a two-tiered abortion system in which the quality of medical care a woman seeking to abort received depended on her class, race and state of residence. Poor and rural women obtained illegal abortions performed by people, not necessarily doctors, willing to defy the law out of sympathy or for the fee. More privileged women crossed state lines or pressed private physicians for legal abortions.[35]

A blanket ban on physician assistance in dying does not support authentic individual choice, and, indeed, is likely to undermine it. Unregulated, renegade doctors, like back-alley abortionists, may utilize a flat ban on physician assisted suicide to obtain patients whose wishes to die may not be tempered by the careful procedural controls necessary to ensure informed consent. Indeed, it is a states's criminalization of this procedure that undermines the legitimate state interest in promoting authentic patient choice. For example, it has been reported that Dr. Kevorkian hastened death for one patient for whom Respondents in this case would not have sought death or help in dying.[36] As with

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abortions. *Id.* In 1959, abortion deaths from illegal abortions accounted for one-third of all maternal deaths. Kristen Luker, *Abortion and the Politics of Motherhood* 74 (1984). In 1927 and 1928, a fifteen-state survey found that 794 women (or ten percent of all maternal deaths) had died from the complications of illegal abortions. *Id.* at 49.

[35] Luker, *supra* note 34, at 57. In addition, in the 1960s, clergy formed problem pregnancy consultation services "that referred women to competent, though illegal, practitioners. These consultation services were used primarily by women of means, not the poor." Jaffe, *supra* note 34, at 22.

[36] For example, Respondent Compassion in Dying

> "will not assist anyone to commit suicide who expresses any ambivalence or uncertainty. If the patient has immediate family members or other close personal friends, their approval must be obtained. . . . Compassion in Dying requires the patient to provide medical records. A consulting physician must review them to verify the patient's terminal prognosis and decision-making capability as well as to rule out inadequate pain management as the reasons for requesting assisted suicide."

Compassion in Dying v. Washington, 850 F. Supp. 1454, 1458 (D. Wash. 1994). Other Respondent physicians would adopt similar norms to assure that patients' requests for assistance in dying is voluntary, informed and uncoerced.

Dr. Kevorkian, a retired pathologist, does not appear to apply such safeguards to assure that patients are terminally ill or that their consent is authentic and informed. From a woman's point of view, the facts of *People ex rel. Oakland County Prosecuting Attorney v. Kevorkian*, 534 N.W.2d 172, 173 (Mich. Ct. App. 1995), *cert. denied sub nom. Kevorkian v. Michigan*, 117 S. Ct. 296 (1996), are especially disturbing. Janet Adkins was 54 years old. She was diagnosed as suffering from Alzheimer's disease. But, at the time Dr. Kevorkian "helped" her to die, she "was not terminally ill nor suffering from pain." *Id.* at 174. She had played tennis within days of her death. Yet, Dr. Kevorkian "made no real effort to discover whether Ms. Adkins wished to end her life, relying largely on the statements of her husband and a few limited responses from Mrs. Adkins." *Id.*

[37] Although prosecutors often sought indictments against illegal abortionists, juries rarely returned convictions. Luker, *supra* note 34, at 53. Convicted abortionists were often dealt with leniently:

> "A statistical analysis of all 111 convictions for abortion in New York County between 1925 and 1950 (about four convictions per year) indicates that 44 percent of those convicted were given probation. This is all the more remarkable when it is realized that . . . in 10 percent of the cases the woman had died as a result of the abortion."

Id. at 53-54. The experience of Dr. Kevorkian has been similar to that of the back-alley abortionist. Kevorkian has admitted to being present at 44 deaths since 1990. *See* Bill Varner, *Kevorkian vs. the Prosecutor: a Last Attempt at Conviction by Thompson*, USA Today, Nov. 1, 1996, at 3A. He has been charged with and tried for crimes stemming from his actions three times and each time he has been acquitted. *See Kevorkian Faces New*

abortion, when the criminal law prohibits ethical doctors from providing patients the help they need to exercise fundamental life choices, patients turn to alternative, often inferior practitioners. Similarly, as with abortion, juries often are unwilling to enforce a blanket ban that condemns all those who seek to help patients exercise fundamental liberties.[37]

As with abortion services before legalization, the blanket ban against doctor-assisted suicide has created a two-tier system where the wealthy and privileged continue to exercise a fundamental right that they would deny to those they consider vulnerable to coercion. John H. Pickering, Senior Counsel to Wilmer, Cutler & Pickering and Counsel of Record for the *Amicus* American Geriatrics Society supporting the States in these cases, defends criminal sanctions against doctors who help terminally ill patients exercise choice in the face of death on the ground that we need to protect the most vulnerable segments of our society—the elderly, the poor and persons with disabilities.[38] No one could challenge this as a valid public policy. Such protectionist policies, however, create real world conundrums and double standards, as revealed by Mr. Pickering's frank admission that, "[a]t the same time I selfishly reserve my right to do in private what my family, my doctor and pastor and I, in loving consultation, voluntarily agree is best."[39] Respondents simply argue that everyone should have this "right" to choose that Mr. Pickering assumes is his.

If the States' position were accepted, an individual's ability to make certain highly intimate and personal choices—whether those choices are about procreation, abortion, or death—could be denied through a blanket ban that guards against some hypothetical threat posed by the exercise of that liberty. Moreover, fundamental liberty could be denied by a state if this Court were to defer to a state's judgment that a flat criminal ban is the best way to protect those who are

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Charges, Reuters, Ltd., Oct. 31, 1996.

[38] *See* Brief for *Amicus Curiae* American Geriatrics Society at 23-26.

[39] John H. Pickering, *The Continuing Debate Over Active Euthanasia*, 3 A.B.A. Bioethics Bull. 1, 15 (1994).

vulnerable to coercion. That cannot be the law.[40] A state does not advance its interest in prohibiting coercion by enacting a blanket ban that prevents free and voluntary decisions regarding highly personal and intimate matters, including decisions to hasten death in the face of terminal illness. Women's experience shows that such protectionist, blanket bans stifle authentic choice and force individuals to exercise their rights in unsafe and unregulated environments.

IV. THE STATES' CLAIM THAT CRIMINAL SANCTIONS MAY BE IMPOSED TO PROTECT LIFE OVER THE OBJECTION OF THE COMPETENT, TERMINALLY ILL PERSON WHO LIVES IT POSES A SPECIAL THREAT TO WOMEN.

The States claim that a blanket ban against doctor-assisted suicide advances a legitimate interest in preserving life.[41] Women have confronted similar arguments in the context of overbroad laws that infringe their fundamental right to exercise liberty over their own bodies and lives by choosing an abortion. In that context, this Court rejected the argument that the state has an uncompromising interest in protecting potential life that could justify the criminalization of all abortions.[42] This Court balanced the state's interest in

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[40] *See Casey*, 505 U.S. at 869 ("[l]iberty must not be extinguished for want of a line that is clear"); *Cruzan*, 497 U.S. at 355 ("[T]his Court cannot defer to any state policy that drives a theoretical wedge between a person's life, on the one hand, and that person's liberty or happiness, on the other. The consequence of such a theory is to deny the personhood of those whose lives are defined by the State's interests rather than their own.") (Stevens, J., dissenting).

[41] New York Br. at 20-26; Washington Br. at 34.

[42] *See Casey*, 505 U.S. at 857 ("our cases since *Roe* accord with *Roe*'s view that a State's interest in this protection of life falls short of justifying any plenary override of individual liberty claims").

protecting potential life against the interest of women in obtaining an abortion, and expressly held that the former must yield to the latter until the potential life at issue (the fetus) is viable. *Roe*, 410 U.S. at 162-63; *Casey*, 505 U.S. at 870-71. Moreover, even after the point at which a fetus becomes viable, a woman's liberty interest in preserving her own life or health overrides the state's interest in protecting the potential life of the fetus. *Roe*, 410 U.S. at 164-65; *Casey*, 505 U.S. at 846.

The States' asserted interest in protecting life must be balanced against the right of the terminally-ill to choose the time and manner of their own death. That balance tips decidedly in favor of the liberty interest of terminally ill patients. The state does not have an interest in preserving the life of all citizens at all times and under all situations. This Court recognized in *Cruzan* that a person has a constitutionally protected liberty interest in refusing unwanted medical treatment, 497 U.S. at 278, which means that the state's interest in protecting life cannot override the right of a person to hasten death by discontinuing a life support system. *Id.* at 288 ("Such forced treatment may burden that individual's liberty interests as much as any state coercion") (O'Connor, J., concurring). As with individuals whose lives are sustained by permanent life support systems, the state has no interest in preventing a competent, terminally ill person who is suffering severe and untreatable pain from hastening his or her own death.[43]

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[43] As Justice Stevens stated in *Cruzan*, "[h]owever commendable may be the state's interest in human life, it cannot pursue that interest by appropriating Nancy Cruzan's life as a symbol for its own purposes. Lives do not exist in abstraction from persons, and to pretend otherwise is not to honor but to desecrate the State's responsibility for protecting life". 497 U.S. at 356-57.

The States may have a legitimate interest in protecting life by preventing doctors, family members and others from coercing a terminally ill person to hasten his or her own death. Indeed, such an interest is fully consistent with the fundamental right of a terminally ill person to hasten death. By preventing coercion through the reasoned regulation of an individual's exercise of his or her liberty, a state can actually protect the fundamental right to hasten death by assuring that the right is exercised knowingly and voluntarily. *See supra* at 17-18. However, a law that criminalizes all doctor assisted suicide impermissibly infringes upon that right and relegates those who choose to exercise their right despite the state's prohibition to the realm of the uninformed, unsafe and unregulated.

V. THE CLAIM THAT THE CONSTITUTION PROHIBITS ONLY LAWS THAT ARE INVALID IN EVERY IMAGINABLE CIRCUMSTANCE IS INCONSISTENT WITH ESTABLISHED SUPREME COURT PRACTICE.

Before being reversed *en banc*, the three judge Ninth Circuit decision below held that the challenged statute must be upheld because "there were circumstances in which the statute could operate constitutionally, for example to deter suicide by teenagers or to prevent fraud upon the elderly".[44] The principle applied by the three judge panel was first articulated in *United States v. Salerno*, where the Court stated in dictum that a challenge to an overbroad law that denies constitutional liberty must be rejected unless "no set of circumstances exist under which the [law] would be valid". 481 U.S. 739, 745 (1987). That principle has no application in these cases and, in any event, is not the law.

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[44] *Compassion in Dying*, 49 F.3d at 591.

The rule articulated in *Salerno* has no application to these cases because Respondents challenge the laws at issue here as applied only to them and similarly situated people and seek a remedy to protect the constitutional right that they assert. In its *en banc* decision, the Ninth Circuit explicitly held that the blanket prohibition on physician assisted suicide is unconstitutional only insofar as it is "applied to the prescription of life-ending medication for use by terminally ill, competent adult patients who wish to hasten their deaths".[45] The States do not challenge the Ninth Circuit's rejection of the *Salerno* rule or argue that these are appropriate cases for this Court to adopt the rule they urged below.

Further, the novel claim that courts may not recognize violations of fundamental constitutional liberty unless it is possible to say that the law challenged is unconstitutional in every conceivable circumstance is not, and has never been the law. For example, in *Griswold*, plaintiff physicians, on behalf of married patients, challenged a law that prohibited doctors from prescribing contraceptives for any patient.[46] If the peculiar new remedial notion urged by the States in the lower courts had been the law in 1965, the Court would have denied relief in *Griswold* because the blanket ban might have been

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[45] *Compassion in Dying*, 79 F.3d at 798. Similarly, the Second Circuit held "that physicians who are willing to do so may prescribe drugs to be self-administered by mentally competent patients who seek to end their lives during the final stages of a terminal illness. *Quill*, 80 F.3d at 718.

[46] The Connecticut statute challenged in *Griswold* read: "Any person who uses any drug, medical article or instrument for the purpose of preventing conception shall be fined not less than fifty dollars or imprisoned not less than sixty days nor more than one year or be both fined and imprisoned". 381 U.S. at 480. Upon finding the law unconstitutional, the Court ordered that the criminal convictions be reversed and the law be struck. *Id.* at 485-86, 499.

constitutional as applied to unmarried teenagers or to doctors prescribing contraceptives that were, for example, ineffective and dangerous. That was not the approach adopted in *Griswold*. Rather the Court considered the claim presented to it, held that the law was unconstitutionally overbroad and reversed the criminal convictions of the parties before it.[47]

The wiser and accepted course in cases challenging broad criminal statutes that violate constitutional liberty is simply to hold that the law is unconstitutional as applied to the parties before the Court and those who are similarly situated or to strike the law as unconstitutional on its face. This allows state legislatures to craft laws that protect legitimate state concerns, without overbroad infringement of constitutional liberty. It invites state and federal legislatures to "participate in a dialogue" and to act to develop more refined approaches that both respect fundamental individual choice and protect against coercion and abuse.[48]

This radical concept that a court may not protect a violation of constitutional liberty unless the challenged law is unconstitutional in every conceivable circumstance has been applied by some judges in cases challenging restrictive abortion laws that plainly violate the rights affirmed in *Casey*.[49] It would, if adopted, extend the substantive rule of

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[47] The Connecticut Court of Errors set aside the defendants' convictions and remanded to the trial court for further proceedings consistent with the judgment of the Court. *Griswold v. Connecticut*, 213 A.2d 525 (1965). The Connecticut legislature repealed the challenged laws. 1969 Conn. Pub. Acts 282, § 214 (eff. Oct. 1, 1971).

[48] Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185, 1198, 1204 (1992).

[49] *Ada v. Guam Soc'y of Obstetricians & Gynecologists*, 506 U.S. 1011 (1993) (Rehnquist, C.J., White, J., and Scalia, J., dissenting from the denial of *certiorari*); *Barnes v. Moore*, 970 F.2d 12, 14 & n.2 (5th Cir.), *cert. denied*, 506 U.S. 1021 (1992).

deference to state discretion to regulate economic affairs to cases in which the Court has found that a law burdens a fundamental personal liberty without justification. It would use the remedial phase of constitutional adjudication to enshrine substantive constitutional principles wholly deferential to state power.[50] As Justice Stevens has noted, "*Salerno*'s rigid and unwise dictum has been properly ignored in subsequent cases".[51] Certainly it has no application to these cases in which Respondents challenge the application of absolute bans that deny them their fundamental rights of liberty and serve no legitimate state purpose.

As the Court recognized in *Cruzan*, "in deciding 'a question of such magnitude and importance . . . it is the [better] part of wisdom not to attempt, by any general statement, to cover every possible phase of the subject.'" 497 U.S. at 277-78 (citing *Twin City Bank v. Nebeker*, 167 U.S. 196, 202 (1897)).

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[50] Sylvia A. Law, *Physician-Assisted Death: An Essay on Constitutional Rights and Remedies*, 55 Maryland L. Rev. 292, 324-341 (1996).

[51] *Janklow v. Planned Parenthood, Sioux Falls Clinic*, 116 S. Ct. 1582, 1583 (1996) (memorandum opinion concurring in denial of petition for *certiorari*).

CONCLUSION

For the foregoing reasons, the decisions of the Courts of Appeals should be affirmed.

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Nos. 95-1858 and 96-110

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, Attorney General
of the State of New York, *et al.*,
Petitioners,

v.

TIMOTHY QUILL, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

STATE OF WASHINGTON, *et al.*,
Petitioners,

v.

HAROLD GLUCKSBRG, M.D., *et al.*,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICUS CURIAE* OF STATE LEGISLATORS IN SUPPORT OF RESPONDENTS

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50 pp

Table of Contents

Table of Authorities iii

Interest of Amici 1

Summary of Argument 1

Argument 4

I. The Right of a Mentally Competent, Terminally Ill Adult to the Assistance of a Willing Physician in Carrying out a Decision About How to Live Life's Final Days is an Essential Aspect of the Liberty Protected by the Due Process Clause of the Fourteenth Amendment 4

II. The Equal Protection Clause of the Fourteenth Amendment Provides an Alternative Basis for Affirming the Rulings Below, but Whether Viewed as a Question of Due Process Liberty or Equal Protection, the Central Question in these Cases is Whether the States have Offered a Sufficient Justification for Overriding Personal Autonomy 12

III. No State Interest Justifies a Blanket Prohibition on a Mentally Competent, Terminally Ill Patient's Exercise of the Right to the Assistance of a Willing Physician in Carrying out his or her Decision About how to Live Life's Final Days 15

A. The State's Interest in Protection and Preservation of Life, *Simpliciter*, Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days 17

B. The State's Interest in Prevention of Suicide Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days 20

C. The State's Interest in Preventing Coercion or Undue Influence Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days 21

D. The State's Interest in Protecting the Handicapped and Other Disadvantaged Members of Society Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days 24

E. The State's Interest in Maintaining the Ethical Integrity of the Medical Profession Does Not Justify an Outright Ban on Physicians Rendering Assistance to Mentally Competent, Terminally Ill Patients in Carrying out Decisions About how to Live Life's Final Days 25

IV. Affirming the Judgments Below Would Give Proper Recognition to the Principle that this Court Shares Responsibility with the State and Federal Legislatures for Striking a Balance Between Constitutional Rights and Government Regulation 27

Conclusion 30

Appendix A (Recent Proposals and Enactments) 1a

Appendix B (List of Amici). 13a

Table of Authorities

Cases

Bates v. State Bar, 433 U.S. 350 (1977) 25
Bolling v. Sharpe, 347 U.S. 497 (1954). 14
Bowers v. Hardwick, 478 U.S. 186 (1986) 13
Brown v. Board of Educ., 347 U.S. 483 (1954) 9
Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996) (en banc) . . . . . *passim*
Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) . . . . . *passim*
Daniels v. Williams, 474 U.S. 327 (1986) 5
Florida Bar v. Went For It, Inc., 115 S. Ct. 2371 (1995) 25
Garger v. New Jersey, 429 U.S. 922 (1976). 28
In Re Joseph G., 667 P.2d 1176 (Cal. 1993) 11
In re Quinlan, 70 N.J. 10, *cert. denied sub nom Garger v. New Jersey*, 429 U.S. 922 (1976) 28
Loving v. Virginia, 388 U.S. 1 (1967). 9
McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316 (1819). 27
Meyer v. Nebraska, 262 U.S. 390 (1923). 6
Michael H. v. Gerald D., 491 U.S. 110 (1989) 2,11
Moore v. City of East Cleveland, 431 U.S. 494 (1977) 10
Mugler v. Kansas, 123 U.S. 623 (1887) 5
Pierce v. Society of Sisters, 268 U.S. 510 (1925) 6
Planned Parenthood. v. Casey, 505 U.S. 833 (1992). . . . . *passim*
Quill v. Vacco 80 F.3d 716 (2d. Cir. 1996) . . . . . *passim*
Rochin v. California, 342 U.S. 165 (1952). 28
Roe v. Wade, 410 U.S. 113 (1973) 4,16
Romer v. Evans, 116 S. Ct. 1620 (1996) 13
San Antonio Indep. School Dist. v. Rodriguez, 411 U.S. 1 (1973) 13
State v. Bauer, 471 N.W.2d 363 (Minn. App. 1991) 11
Washington v. Harper, 494 U.S. 210 (1990) 6
Whitney v. California, 274 U.S. 357 (1927). 4
Youngberg v. Romeo, 457 U.S. 307 (1982) 7
Zablocki v. Redhail, 434 U.S. 374 (1978) 12, 14

Miscellaneous

Bachman, *Assisted Suicide and Active Euthanasia in Michigan*, 31 New Eng. J. Med. 812 (1994) 26
Brief of the American Medical Association, *et al.* (No. 95-1858) . . . . . *passim*
Brief Amicus Curiae of the Catholic Medical Association 24
Brief Amici Curiae of the National Legal Center for the Medically Dependent & Disabled, Inc. 24
Brief Amicus Curiae on Behalf of Members of the New York and Washington State Legislatures in Support of Petitioners 11, 16
Brief of Amicus Curiae State of Oregon in Support of Petitioners (No. 96-110) 15
Brief for the Petitioners, (No. 96-110) . . . . . *passim*
Brief for the United States as amicus curiae Supporting Petitioners (No. 96-110) 9, 21
Brief for Petitioners Vacco and Pataki, (No. 95-1858) . . . . . *passim*
Cohen, *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89 (1994) 26
Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235 (1994) 13
Dorf, *Incidental Burdens on Fundamental Rights*, 109 Harv. L. Rev. 1175 (1996) 13
Dworkin, *Freedom's Law: The Moral Reading of the American Constitution* (1996) 17
Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185 (1992) 20
Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure (1996) 22
Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 469 (1897). 2
Hovenkamp, *The Cultural Crisis of the Fuller Court*, 104 Yale L. J. 2309, (1995) 10
Miller, et. al., *Regulating Physician Assisted Death*, 331 New Eng. J. Med. 119 (1994) 23
N.Y. Penal Law § 120.30 (McKinney 1987) 1
N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993) 22

Note: *Justice Stevens' Equal Protection Jurisprudence*, 100 Harv. L. Rev. 1146 (1987) 13
Nowak and Rotunda, Constitutional Law (5th ed. 1995) 12
Poll Shows that 1 in 5 Internists has Helped a Patient Die, Am. Med. News (Mar. 16, 1992) at 9 3
Proceedings of the AMA House of Delegates 40-51 (June 1967) 25
Quill, *Care of the Hopelessly Ill*, 327 New Eng. J. Med. 1380 (1992) 22
Shapiro, *Willingness to Perform Euthanasia*, 154 Archives Internal Med. 575 (Mar. 14, 1994) (WL, AMA-JNLS database) 26
Shaw, Letter: *Economics and the Examination Room: An Incident*, 347 Lancet 124 (1996) 26
Terminal Sedation in the Care of Dying Patients, Archives Internal Med. (Sep. 9, 1996) (WL, AMA-JNLS database) 28
Tribe & Dorf, On Reading the Constitution (1991) 7
Tribe and Dorf, *Levels of Generality in the Definition of Rights*, 57 U. Chi. L. Rev. 1057 (1990) 10
van Vliet, *The Uneasy Decriminalization: A Perspective on Dutch Drug Policy*, 18 Hofstra L. Rev. 717 (1990) 4
Wash. Rev. Code Ann. § 11.94.010(3) (West Supp. 1996) 22
Wash. Rev. Code Ann. § 9A.36.060 (West 1988) 1

Interest of Amici[1]

Amici are members of the legislatures of sixteen States, including New York and Washington. Within our federal system, amici recognize that their obligations as representatives of the People of the several States must coexist with their sworn duty to uphold the Constitution of the United States. Mindful of that duty, amici seek a ruling in this case that preserves both the essential attributes of state sovereignty and the supremacy of federal law. With due respect, the position advocated in this Court by the petitioners and their amici distorts our system of dual sovereignty beyond recognition. Their position implies that to protect a constitutional right is to interfere with state sovereignty. However, especially in a case such as this one -- in which significant room exists for reasonable state regulation that does not infringe the core right asserted -- protection of the constitutional right preserves the proper balance of authority between representative government and constitutional safeguards.

Statement of the Case and Summary of Argument

The States of New York and Washington impose criminal liability on physicians who provide death-inducing medication to mentally competent, terminally ill patients seeking to assert some measure of autonomy over the waning months, weeks or days of their lives. *See* N.Y. Penal Law § 120.30 (McKinney 1987); Wash. Rev. Code Ann. § 9A.36.060 (West 1988). The Courts of Appeals for the Second and Ninth Circuits held that these statutes, respectively, violate the Equal Protection and Due Process Clauses of the Fourteenth Amendment, as applied to physicians and patients in respondents' circumstances. *Quill v. Vacco*, 80 F.3d 716 (2d Cir. 1996); *Compassion in Dying v. Washington*, 79 F.3d 790 (9th Cir. 1996) (en banc).

Although the state prohibitions at issue here take the nominal form of a failure to provide an exemption from the States' general prohibition on assisting suicide, these cases no more involve an asserted "right to suicide" than an as-applied challenge to a State's

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[1] The parties' letters consenting to the filing of this brief have been filed with the Court. *See* Sup. Ct. R. 37.3. A list of the amici appears in Appendix B to this brief.

failure to exempt pre-viability abortions from its prohibition on homicide would involve a "right to murder." Rather, these cases raise the question whether the States may require that an individual's final stage of life be filled with suffering without proffering any stronger justification for failing to adopt more measured safeguards than that such complete prohibitions were "laid down in the time of Henry IV." Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 469 (1897).

This Court has long recognized that the State must offer some special justification for seeking to control central, intimate, personal decisions. *See Planned Parenthood v. Casey*, 505 U.S. 833 (1992). Indeed, in *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), the Court assumed "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," including lifesaving food and water. *Id.* at 278. That assumption was an express condition of the concurrence of the fifth Justice. *See id.* at 289 (O'Connor, J., concurring).

From the perspective of a suffering patient, the interest at stake in seeking medication for the purpose of causing death does not differ from the interest at stake for a patient who, for the purpose of causing death, seeks to discontinue a course of medical treatment. To be sure, there are circumstances in which the State may distinguish between, on the one hand, refusing medical treatment and, on the other, bringing about death through other means. But it hardly follows that the State may therefore employ the distinction under *all* circumstances. At the very least, the State must offer some substantial reason why the ability of a mentally competent, terminally ill patient to seek a physician's assistance in ending his or her suffering should depend upon the fortuity of whether he or she happens to be undergoing some course of treatment the discontinuation of which would cause death.

The fact that the State has traditionally had the power to prohibit assisted suicide cannot, by itself, justify infringing the liberty of respondents. This Court has consistently rejected the claim that constitutional liberty should be measured by reference to "the most specific level at which a relevant tradition protecting, or denying protection to, the asserted right can be identified." *Michael H. v. Gerald D.*, 491 U.S. 110, 127 n.6 (1989) (Scalia, J., joined by Rehnquist, C.J.). Instead, fidelity to the enduring constitutional

principles of this Court's prior cases requires that the liberty asserted be measured against those very principles. *See id.* at 132 (O'Connor, J., joined by Kennedy, J., concurring) (disagreeing with the narrow historical approach).

As this Court made clear in *Casey*, although the case for a woman's constitutional liberty to decide whether to have an abortion is a clearly convincing one, abortion nonetheless presents a difficult question because the State has a strong interest in the life of the fetus to be weighed against the woman's liberty. 505 U.S. at 871. By contrast, no interest of comparable dimension, and certainly no interest sufficient to justify an outright ban on the decisions at issue here, can be advanced by the State.

Nevertheless, the State has valid interests that justify careful regulation of the decision of a mentally competent, terminally ill patient to seek the assistance of a physician in carrying out his or her wishes about how to live life's final days. These interests include ensuring: that the patient is competent to make a decision; that the patient truly wishes to die; that the decision is not the product of coercion or undue pressure; that the patient has been made aware of alternatives that would ease his or her suffering; and that state recognition of the limited right sought here would not send a broader signal condoning suicide in general. Because careful regulations can be crafted to serve each of these legitimate interests (as well as others), the States' complete prohibitions must be deemed undue intrusions.

Carefully drawn regulations would also be more effective than the complete bans in furthering the State's legitimate ends. Notwithstanding laws like those at issue here, many physicians have in fact helped their patients to die;[2] yet "[t]here is no reported American case of criminal punishment being meted out to a doctor for helping a patient hasten his own death." *Compassion in Dying*, 79 F.3d at 811. Official criminalization assures that doctors who render aid in dying act in secrecy, or worse, that many patients seek out back-alley assistance from the unscrupulous. In this sense, current law in New York, Washington and most other States closely resembles the Dutch model of tacit approval of an illegal act. *See*

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[2] In a recent poll, 20% of the doctors surveyed admitted to having helped a patient to die. *See Poll Shows that 1 in 5 Internists has Helped a Patient Die*, Am. Med. News (Mar. 16, 1992) at 9.

Brief of the American Medical Association, *et al*, at 12-13 (No. 95-1858) (conceding that physician-assisted suicide is illegal but not prosecuted under Dutch law). The divergence between *de jure* and *de facto* rules of law that characterizes the Netherlands,[3] is an inappropriate model for the United States. Yet that is the regime that petitioners ask this Court to validate.

Finally, this Court should not reverse the decisions below in the vain hope of avoiding difficult line-drawing decisions. A decision to reverse would call for the drawing of seemingly purposeless lines and the creation of bizarre categories; for example, it would require the Court to explain the sense in which a doctor's violent removal of a large tube from a patient's esophagus is "inaction," while the patient's self-administration of a pill constitutes "action" by the doctor. *See* Brief for Petitioners Vacco and Pataki at 16-17 (No. 95-1858). Perhaps such seemingly arbitrary distinctions are permissible when all that is at stake is regulation of purely economic transactions, but not when the case involves intimate, personal, self-defining decisions -- as these cases undoubtedly do.

Argument

I. The Right of a Mentally Competent, Terminally Ill Adult to the Assistance of a Willing Physician in Carrying out a Decision About How to Live Life's Final Days is an Essential Aspect of the Liberty Protected by the Due Process Clause of the Fourteenth Amendment.

In *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), a majority of this Court reaffirmed "the essential holding" of *Roe v. Wade*, 410 U.S. 113 (1973). *Casey*, 505 U.S. at 846. In the course of explaining the basis for its decision, this Court made clear its continued adherence to the century-old principle that the Due Process Clause of the Fourteenth Amendment protects "all fundamental rights comprised within the term liberty," *Whitney v. California*, 274 U.S. 357, 373 (1927) (Brandeis, J., joined by

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[3] *See also* van Vliet, *The Uneasy Decriminalization: A Perspective on Dutch Drug Policy*, 18 Hofstra L. Rev. 717, 731 (1990) (noting that Dutch law makes possession of marijuana and hashish a crime, but other principles prevent enforcement of the prohibition).

Holmes, J., concurring), against undue state interference. *See Casey*, 505 U.S. at 846-47 (citing *Mugler v. Kansas*, 123 U.S. 623, 660-61 (1887), *Daniels v. Williams*, 474 U.S. 327, 331 (1986), and *Whitney*). The *Casey* Court reaffirmed that the Due Process Clause protects not only the rights expressly enumerated in the Bill of Rights, nor only "those practices, defined at the most specific level, that were protected against government interference by other rules of law when the Fourteenth Amendment was ratified." 505 U.S. at 847. "It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter." *Id.* If this Court's liberty jurisprudence is to remain principled, that realm must include the decision of a mentally competent terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days.

This Court's decision in *Casey* rested on more than just the principle of *stare decisis*. In the first portion of the *Casey* opinion, the Court unhesitatingly re-affirmed the existence of a constitutionally inviolable realm of individual conscience. To the extent that the *Casey* Court relied on the principle of *stare decisis* as a supplement to its basic reasoning, it did so for purposes of assessing the State's countervailing interest in fetal life. As the Court stated, "[t]he weight to be given [the] state interest [in fetal life], not the strength of the woman's interest, was the difficult question faced in *Roe*." 505 U.S. at 871.

The individual right claimed in the present cases falls squarely within the zone of liberty that the *Casey* Court reaffirmed without reliance upon the doctrine of *stare decisis*. The *Casey* majority reaffirmed the constitutional theory and practice guaranteeing protection for marriage, procreation, contraception, family relationships, child rearing, and education, 505 U.S. at 851, stating that

> [t]hese matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

Id.

Let there be no mistake. These carefully chosen words from one of the century's most closely watched and hard-fought cases do not bear some mere accidental relation to the cases now before the Court. A terminally ill patient who needs the aid of a willing physician to end his or her suffering and to preserve what the patient believes to be his or her dignity faces a critical self-defining choice. To hold that such a decision is qualitatively less intimate, personal or central than decisions about where to send one's child to school, *see Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923), would do irreparable damage to this Court's commitment to principled exposition of constitutional rights.

Even before *Casey's* careful reaffirmation of the constitutional basis for a protected zone of liberty, this Court made clear that end-of-life decisions implicate that protected zone. In *Cruzan v. Director, Missouri Dept. Of Health*, 497 U.S. 261 (1990), the Court began its analysis by recognizing that its prior cases support "[t]he principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment . . . ." *Id.* at 278. The majority opinion assumed for purposes of that case that a competent person has "a constitutionally protected right to refuse lifesaving hydration and nutrition." *Id.* Justice O'Connor -- who provided the critical fifth vote for the *Cruzan* majority -- did not merely assume such a right. Her concurrence depended on the understanding that "the liberty guaranteed by [the Due Process Clause] must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water." *Id.* at 289 (O'Connor, J. concurring). *Accord Washington v. Harper*, 494 U.S. 210, 221-22 (1990) (in the course of upholding state procedural scheme, stating "[w]e have no doubt that, in addition to the liberty interest created by the State's Policy, respondent possesses a significant liberty interest in avoiding the unwanted administration of antipsychotic drugs under the Due Process Clause of the Fourteenth Amendment").

To be sure, *Cruzan* used the language of "liberty interests" rather than "fundamental rights," 497 U.S. at 278, but then *Casey* similarly eschewed the fundamental rights label. More important than the precise doctrinal pigeonhole into which one places these cases is the fact that both *Casey* and *Cruzan* recognized that when

the State seeks to infringe basic liberties, it must show that doing so will advance interests of comparable weight. *See Casey*, 505 U.S. at 875-76; *Cruzan*, 497 U.S. at 279 ("'whether respondent's constitutional rights have been violated must be determined by balancing his liberty interests against the relevant state interests.'") (quoting *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982)).

Because of the exceedingly strong precedent supporting recognition of the right asserted here, petitioners resort to elaborate but unavailing argumentative gymnastics in their efforts to distinguish this Court's earlier decisions. They contend that the right recognized by a majority of this Court in *Cruzan* is only a right to refuse the imposition of unwanted medical treatment in the form of artificial life support or hydration and nutrition, rather than what they term *active* assistance. *See* Brief for Petitioners Vacco and Pataki at 16-17 (No. 95-1858). Petitioners offer two kinds of reasons for this distinction. First, they point to a variety of public policies which, they allege, are undermined by permitting so-called *active* death-hastening measures by doctors. Second, they contend that as an historical matter, the common law right given constitutional recognition in *Cruzan* does not extend beyond refusing or discontinuing medical treatment. Neither kind of reason provides a constitutional basis for the distinction proffered.

By invoking public policies that supposedly would be offended by permitting "active" death-hastening measures, petitioners and their amici seek to obscure the fact that *from the perspective of the individual*, the interest of a mentally competent, terminally ill adult in obtaining a physician's "active" aid in dying is identical to the interest in terminating life-support. This Court must therefore measure the public policies offered in support of the laws under review here *against* the right asserted by the plaintiffs, rather than double-counting these public policies by incorporating them *into* the definition of the right. If the State could show that its asserted policies justified overriding respondents' strong liberty interest, that would provide a constitutional basis for denying recognition to the right. However, "[w]hen the factors that provide the state's possible justifications for its regulation are automatically incorporated into the initial definition of a liberty, the fundamental nature of that liberty inevitably vanishes." Tribe & Dorf, On Reading the Constitution 107 (1991). As will be shown below, the proffered state interests cannot justify the blanket prohibitions before this

Court. Before addressing the state interests, however, this Court must examine the intended impact of the laws on the individuals subject to them. *Cf. Casey,* 505 U.S. at 894 ("The analysis does not end with the [persons burdened by the law]; it begins there. Legislation is measured for consistency with the Constitution by its impact on those whose conduct it affects.") That impact can only be described as enormous.

Viewing the relevant constitutional right recognized by this Court's prior cases as one of personal autonomy makes clear that the right encompasses the cases now before the Court. No volume of citations or lawyerly argument could refute the obvious fact that "few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." *Compassion in Dying v. Washington*, 79 F.3d 790, 813 (9th Cir. 1996) (en banc).

Indeed, the autonomy interest of a mentally competent, terminally ill patient in physician assistance in carrying out his or her decision about how to live life's final days would appear to be stronger than the right recognized by a majority of this Court in *Cruzan*. Respecting the wish of a person in a vegetative state to have life-sustaining medical treatment withdrawn invariably means respecting that person's *past* wishes -- typically formed at a time when he or she viewed the possibility of ending up in such a state as hypothetical. By contrast, a mentally competent, terminally ill patient acts with full knowledge of the reality and immediacy of the consequences. For the State to prohibit aid in dying for him or her is to interfere with the individual's autonomy in the here and now.

The right of a mentally competent terminally ill patient to physician assistance in carrying out his or her decision about how to live life's final days is also an exemplar of bodily integrity. Petitioners assert that the right to bodily integrity merely prohibits the State from imposing unwanted intrusions on the person. *See* Brief for the Petitioners at 30 (No. 96-110); Brief for Petitioners Vacco and Pataki at 9-11 (No. 95-1858). The act/omission distinction thus advanced is incoherent in the present cases, as a comparison with the abortion decisions reveals.

This Court has recognized the abortion right as grounded, *inter alia*, in bodily integrity. *See Casey*, 505 U.S. at 857. Yet the act of abortion constitutes affirmative intervention (by a physician, it should be noted) with a pregnant woman's "natural" state. Abortion

restrictions interfere with the right of bodily integrity because they have the effect of requiring the physical privations of pregnancy -- even though those privations occur as a natural result of the woman's condition. In the same way, prohibitions on physician assistance in the carrying out of end-of-life decisions interfere with the right of bodily integrity because they have the effect of requiring the physical and emotional privations of the illness from which the patient suffers -- even though those privations occur as a natural result of that illness. This Court's recognition that the abortion right is rooted in the right to bodily integrity thus inevitably implies that the right of a terminally ill patient to assistance in carrying out his or her decision about how to live life's final days is rooted in the same right to bodily integrity.[4]

Petitioners rely on a discredited narrow form of historical analysis in their efforts to carve out an ad hoc exception to this Court's liberty jurisprudence. They contend that the mixed historical pedigree of the constitutional right claimed here precludes its recognition. *See* Brief for the Petitioners at 21-25 (No. 96-110); Brief for Petitioners Vacco and Pataki at 11-13 (No. 95-1858). In its landmark decisions recognizing constitutional protection for liberty and equality, this Court has never considered itself bound by the kind of narrow historicism that petitioners and their amici contend should guide the decision in the present cases. The consistency of racial segregation with equal protection of the laws was widely assumed at the time of the adoption of the Fourteenth Amendment, *see, e.g.,* Hovenkamp, *The Cultural Crises of the Fuller Court*, 104 Yale L.J. 2309, 2338-40 (1995), yet that did not prevent a contrary conclusion in *Brown v. Board. of Educ.*, 347 U.S. 483 (1954). Similarly, as the *Casey* Court recognized, in *Loving v. Virginia*, 388 U.S. 1 (1967), eight Justices found that anti-miscegenation statutes violated the fundamental liberty to marry, notwithstanding the widespread acceptance of such prohibitions at the time of the adoption of the Due Process Clause and for a long

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[4] The United States attempts to distinguish *Roe* and *Casey* on the ground that abortion prohibitions produce the responsibilities of parenthood as well as the suffering associated with pregnancy. *See* Brief for the United States as Amicus Curiae Supporting Petitioners at 16-17 (No. 96-110). But that factor has no independent weight, for if it did, then a man would have a constitutional liberty in forcing his mate to have an abortion, and biological parents would have a similar liberty to commit infanticide.

time thereafter. *See Casey*, 505 U.S. at 847-48 (citing *Loving*, 388 U.S. at 12).[5]

Of perhaps greatest significance, the *Cruzan* Court itself did not inquire into whether the common law traditionally protected a specific right to the removal of nutrition and hydration, nor did it even accord significant weight to the contemporary treatment by state legislatures of that precise act. After canvassing the evolving approach in the state courts, this Court concluded in broad terms:

> As these cases demonstrate, the common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. Beyond that, these cases demonstrate both similarity and diversity in their approaches to decision of what all agree is a perplexing question with unusually strong moral and ethical overtones.

497 U.S. at 277. The Court then exercised its own judgment in assuming that this right included rejecting nutrition and hydration. *See id.* at 279.

Justice O'Connor's crucial concurring opinion in *Cruzan* used

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[5] Petitioners in No. 96-110 attempt to distinguish *Loving* by noting that "'[t]he freedom to marry has long been recognized as one of the vital personal rights essential to the orderly pursuit of happiness,' even though the right to inter-racial marriage has no similar historical pedigree. Brief for the Petitioners at 22 (quoting *Loving*, 388 U.S. at 12). But this point merely underscores the flaw in petitioners' basic mode of analysis. The *Loving* Court found it sufficient that the very specific right to inter-racial marriage, although itself not "deeply rooted in this nation's history and tradition," *Moore v. City of East Cleveland*, 431 U.S. 494, 503 (1977), was an instance of the broader historical tradition affording protection to marriage and other intimate associations. So too here, although the very narrow right of a mentally competent, terminally ill patient to the assistance of a willing physician in carrying out a decision about the end of life has not been the subject of positive legal protection, it is an instance of the broader historical and legal tradition affording protection to important intimate and personal decisions. Petitioners are surely right that "[t]he degree of specificity with which the asserted right is described is important and may be determinative of the extent to which the claim of constitutional protection is recognized." Brief for the Petitioners at 19 (No. 96-110) (citing Tribe and Dorf, *Levels of Generality in the Definition of Rights*, 57 U. Chi. L. Rev. 1057 (1990)). Yet they offer no justification for selecting the extremely narrow level at which they focus. By contrast, amici respectfully submit that we have focused at the proper level because, from the perspective of the individual, the right respondents claim commands the same or greater respect as the right recognized in *Cruzan* and this Court's other cases in this area.

the same mode of analysis. After locating a broad right to refuse medical treatment in the Court's prior decisions, Justice O'Connor concluded: "The State's artificial provision of nutrition and hydration implicates identical concerns. Artificial feeding cannot readily be distinguished from other forms of medical treatment." *Id.* at 288 (O'Connor, J., concurring). Thus, in the decision of this Court that most closely resembles the present cases, the Court did not employ the narrow historical methodology that petitioners and their amici advocate. Petitioners and their amici seek to replace this Court's tradition of reasoned elaboration with the oft-rejected view that this Court should only recognize the most specific rights protected by an historical tradition. *See Michael H. v. Gerald D.*, 491 U.S. 110, 132 (1989) (O'Connor, J., joined by Kennedy, J., concurring) (disagreeing with the narrow historical approach).

Similarly unavailing are the efforts of petitioners and their amici to invoke contemporary state practice as a basis for denying respondents' claim of constitutional right. It is that very practice that is under challenge here. Moreover, as the en banc panel of the Court of Appeals for the Ninth Circuit noted below, there is considerable public support for a carefully regulated right of mentally competent terminally ill patients to physician assistance in carrying out their decisions about how to live life's final days. *Compassion in Dying*, 79 F.3d at 810 (citing public opinion polls and the results of the 1994 Oregon referendum). At the same time, even where such assistance is prohibited, the urgency of reform efforts is dampened by the nearly complete lack of enforcement.[6]

Standing alone, current social attitudes and trends in the positive law of the States might not be sufficient to establish a terminally ill patient's constitutional right to autonomy in decisions about how to live life's final days. But these trends and attitudes do not stand alone. Recognition for the right rests on the solid foundation of principled application of decisions this Court has already rendered.

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[6] Apparently conceding the point, petitioners' amici grasp at straws by asserting that "the States do enforce their assisted suicide laws." Brief Amicus Curiae on Behalf of Members of the New York and Washington State Legislatures in Support of Petitioners at 21. This general proposition, however, has no bearing on the specific issue now before the Court, as petitioners' amici cite no case involving a doctor assisting a terminally ill patient. *See id.* at 21 n.15 (citing, *inter alia*, two cases involving teenage suicide pacts, *see In Re Joseph G.*, 667 P.2d 1176 (Cal. 1983); *State v. Bauer*, 471 N.W.2d 363 (Minn. App. 1991)).

At the very least, current social attitudes and trends in state positive law do nothing to undermine the case for the constitutional right advanced here. Indeed, they appear to strengthen that case.

If this Court's liberty doctrine is to remain a jurisprudence of principle and not a mere assortment of ad hoc judgments, it must recognize that the right of a mentally competent terminally ill patient to seek assistance in carrying out his or her decision about how to live life's final days lies at the very core of the constitutionally protected personal autonomy and bodily integrity that this Court has long recognized. Thus, whatever arguments petitioners and their amici advance to distinguish that right must, at the outset, be of sufficient weight to overcome an individual interest of the highest order. As will be shown below, although the State has legitimate regulatory interests in this area, none of them remotely justifies an absolute ban.

II. The Equal Protection Clause of the Fourteenth Amendment Provides an Alternative Basis for Affirming the Rulings Below, but Whether Viewed as a Question of Due Process Liberty or Equal Protection, the Central Question in these Cases is Whether the States have Offered a Sufficient Justification for Overriding Personal Autonomy.

Hornbooks of constitutional law state that laws challenged under the Fourteenth Amendment as infringing rights protected by the Due Process or Equal Protection Clause will be subject to heightened scrutiny if they infringe fundamental rights. *See, e.g.*, Nowak and Rotunda, Constitutional Law § 11.7, at 399 (5th ed. 1995). Otherwise, legislation not employing illicit classifications is subject only to the deferential rational basis test. *See id.*, § 11.4, at 383. Although this framework has the virtue of simplicity, it has two important limitations. First, its on/off character requires the courts to draw somewhat arbitrary lines between fundamental rights and lesser interests. Second, it seems to require the courts to treat all laws affecting fundamental rights with equal suspicion, even though they might serve quite different purposes. For these reasons, it is fair to say that this Court's Fourteenth Amendment jurisprudence was never quite so simple as the hornbooks would suggest. *See Zablocki v. Redhail*, 434 U.S. 374, 386 (1978). *Cf. San Antonio Indep. School Dist. v. Rodriguez*, 411 U.S. 1, 98-110

(1973) (Marshall, J., dissenting); Note: *Justice Stevens' Equal Protection Jurisprudence*, 100 Harv. L. Rev. 1146 (1987).

In *Casey*, the joint opinion of Justices O'Connor, Kennedy, and Souter announced that abortion regulations would be judged according to an undue burden test, under which laws with the purpose or effect of emplacing substantial obstacles in the way of a decision to have an abortion would be held invalid. 505 U.S. at 877. Whether the undue burden test reflects a judgment as to how the strict scrutiny standard ought to apply in the abortion context, *see* Dorf, *Facial Challenges to State and Federal Statutes*, 46 Stan. L. Rev. 235, 272 n.153 (1994), or whether it represents a more general approach to classifying various kinds of burdens on individual rights, *see* Dorf, *Incidental Burdens on Fundamental Rights*, 109 Harv. L. Rev. 1175, 1219-32 (1996), is perhaps an interesting academic question. The import of *Casey* for the present cases, however, is clear: recognition of the right of a mentally competent, terminal patient to seek the assistance of a willing physician in carrying out his or her decision about how to live life's final days does not automatically lead to the invalidation of all laws regulating that decision. Rather, the Court must undertake a careful examination of the ends and means of state regulation.

In its decision below, the Court of Appeals for the Second Circuit believed that it was constrained not to recognize "new" constitutional rights under the Due Process Clause. *See Quill*, 80 F.3d at 724-25. That reluctance was based in part on an overly broad reading of *Bowers v. Hardwick*, 478 U.S. 186 (1986), *see Quill*, 80 F.3d at 724-25, a case whose core holding has been eroded by this Court's decision in *Romer v. Evans*, 116 S. Ct. 1620 (1996), and whose methodology has not been in evidence for quite some time, even in Due Process Liberty cases. The lead opinion in *Casey*, for example, does not even cite *Hardwick*. What remains of *Hardwick* is perhaps a cautionary note with which no sensible student of constitutional law could disagree -- that the Court should tread lightly in defining zones of liberty under the Due Process Clause. Affirming the judgments below would not in any way contravene this caution.[7]

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[7] The Second Circuit also believed itself constrained to avoid a ruling under the Due Process Clause because it is a lower court. *See Quill*, 80 F.2d at 725 ("Our position in the judicial hierarchy constrains us to be even more

More fundamentally, the Second Circuit's own analysis of the Equal Protection issue belies any concern that respondents seek a "new" liberty. The central basis for the Second Circuit's ruling is that the right of a mentally competent, terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days cannot be rationally distinguished from the right of a similarly situated patient to refuse life-saving medical treatment. *See id.* at 725-31. Whether the Court recognizes this linkage as a matter of Due Process or Equal Protection is of much less significance than that the Court recognize its obligation to apply its precedents in a principled manner. *See Bolling v. Sharpe*, 347 U.S. 497, 499-500 (1954) (holding that the Fifth Amendment Due Process Clause prohibits arbitrary classifications, a category largely coextensive with those prohibited by the Fourteenth Amendment's Equal Protection Clause). Distinctions that bear on so intimate and central a choice as the one at issue here must, at the very least, be supported by more than the State's conclusory assertion that it wishes to extend protection to the choice in some circumstances, but not in others.

The Court need not, and probably should not, adopt a doctrinal approach to be used to test all state regulations of, and distinctions regarding, the right of a mentally competent, terminally ill adult to seek the assistance of a physician in carrying out his or her decision about how to live life's final days. To decide this case it is sufficient to ask the States to come forward with some substantial justification for the complete bans at issue. As will be shown in the next section, the States fail this minimal requirement.

Nevertheless, should this Court decide to announce a doctrinal framework applicable to future cases, amici respectfully suggest that the undue burden test elaborated by the joint opinion in *Casey* provides the appropriate framework. That test properly recognizes that not all regulations governing the exercise of a right infringe that right. *See Casey*, 505 U.S. at 874-75; *See also Zablocki*, 434 U.S. at 386 (denying that "every state regulation which relates in any way to the incidents of or prerequisites for marriage must be subjected to rigorous scrutiny.") The undue burden standard of *Casey* requires that only laws with the purpose or effect of placing a substantial

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reluctant than the Court to undertake an expansive approach in this unchartered area."). That constraint, by definition, does not apply to this Court.

obstacle in the path of the right's exercise should be deemed infringements of that right. Whether this standard applies to *all* constitutional rights is a puzzle well beyond the scope of this case. For present purposes, it is sufficient to note that the State has related interests in regulating decisions about abortion and the end of life, so that it would be appropriate to apply the undue burden test here.[8]

Of course, a flat ban on patient choice quite obviously has both the purpose and effect of placing a substantial -- indeed an insurmountable -- obstacle in the path of the exercise of the right asserted here. Thus, the only real question is whether petitioners can come forward with a justification for this severe burden. As will be shown in the next section, they cannot. Whether the Court applies traditional heightened scrutiny or a standard more akin to a balancing test, the measures at issue here simply cannot be sustained.

III. No State Interest Justifies a Blanket Prohibition on a Mentally Competent, Terminally Ill Patient's Exercise of the Right to the Assistance of a Willing Physician in Carrying out his or her Decision About how to Live Life's Final Days.

Recognizing the constitutional dimension of a mentally competent patient's decision to seek a physician's assistance in carrying out his or her decision about how to live life's final days does not, of course, preclude all regulations designed to further the State's important countervailing interests. As respondents have conceded throughout the proceedings below, and as both the Courts of Appeals for the Second and Ninth Circuits recognized, the State does have important regulatory interests. Nevertheless, the mere recitation of state interests cannot be permitted to displace constitutional analysis. In the case of abortion, after all, the State validly asserts an interest in what many people consider to be innocent human life; yet in *Casey*, a majority of this Court understood that even that exceptionally important state interest does

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[8] Thus, there is no reason to conclude that affirming the results below would mean that all "state supervision and regulation in this area will be subject to exacting judicial review." Brief of Amicus Curiae State of Oregon in Support of Petitioners at 1 (No. 96-110).

not invariably override the liberty protected by the Due Process Clause.

The state interests most frequently cited by petitioners and their amici in support of the laws challenged here include: (1) protection and preservation of life, *simpliciter*; (2) prevention of suicide; (3) prevention of coercion and undue influence; (4) prevention of the devaluation of the lives of the handicapped and other disadvantaged members of society; and (5) maintaining the ethical integrity of the medical profession. For completeness, it will be shown below that each of these interests can be readily accommodated by measures falling well short of the outright bans under review here. The Court should not, however, miss the forest for the trees. None of the state interests advanced here weigh as heavily as the interest in innocent human life at stake in the abortion context.[9] If, as the Court has correctly held, that interest cannot justify an outright ban on all abortions, surely the less weighty state interests advanced here cannot justify the outright bans on the exercise of a mentally competent, terminally ill adult's right to seek the assistance of a physician in carrying out his or her own decision about how to live life's final days.

[9] The fact that a fetus is not a person within the meaning of the Fourteenth Amendment, *see Roe v. Wade*, 410 U.S. 113, 156-59 (1973), does not mean that the State has no interest in protecting the fetus. To the contrary, the State has a very strong interest in fetal life, even before viability, *see Casey*, 505 U.S. at 872, but even that very strong interest is insufficient to override the woman's liberty. Petitioners' amici would infer from *Roe*'s conclusion about the constitutional status of the fetus the proposition that in order for respondents to prevail in this Court, they must show that terminally ill patients are not persons within the meaning of the Fourteenth Amendment. *See* Brief Amicus Curiae on Behalf of Members of the New York and Washington State Legislatures in Support of Petitioners at 7-8. Yet the very fact that terminally ill patients *are* persons within the meaning of the Fourteenth Amendment gives rise to their rights under the Due Process and Equal Protection Clauses. For the State to override those claims it must proffer an interest *to be weighed against them*.

A. The State's Interest in Protection and Preservation of Life, *Simpliciter*, Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

This Court's decision in *Cruzan* precludes a conclusion that the State's abstract interest in life can outweigh a patient's right of autonomy in end-of-life decisions. In *Cruzan*, this Court appeared to divide over whether the State may assert a legitimate interest in life, apart from -- and in opposition to -- the wishes of the person whose life is at stake. Speaking for three members of the Court, Justice Brennan averred that "the State has no legitimate general interest in someone's life, completely abstracted from the interest of the person living that life, that could outweigh the person's choice to avoid medical treatment." 497 U.S. at 313 (Brennan, J., dissenting). A fourth member, Justice Stevens, agreed. *See id.* at 331 (Stevens, J., dissenting) (finding "the State's abstract, undifferentiated interest in the preservation of life" an inadequate basis for overriding patient choice). The majority opinion of Chief Justice Rehnquist stated that "a State may properly decline to make judgments about the 'quality' of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual." *Id.* at 282 (opinion of the Court).

Although amici would respectfully suggest that the *Cruzan* dissenters' view is to be preferred,[10] even the view espoused by the Chief Justice in *Cruzan* requires that the individual right be given greater weight than the State's abstract interest in life. The *Cruzan* Court addressed a question that arises amid uncertainty. The Court faced the question of how to balance societal interests against individual choice when the result of individual choice is unknown. The Court determined that, in the light of such uncertainty, the State's abstract interest in life, combined with other legitimate state interests, can justify a procedural mechanism requiring clear and

[10] *See* Dworkin, Freedom's Law: The Moral Reading of the American Constitution 140-43 (1996) (arguing that interests that are detached from any person's well-being ought not be permitted to override an actual person's concrete wishes on matters of self-defining religious or spiritual importance).

convincing evidence of patient intent. Nevertheless, the fact that the Court assumed that a competent patient has a constitutional right to refuse life-saving medical treatment -- a point that was a necessary condition for Justice O'Connor's crucial concurrence -- means that even the *Cruzan* majority assumed that the State's abstract interest in life cannot justify overriding patient choice when that choice is clear.

To say that a competent patient would have the right to refuse life-saving medical treatment is to say that *no state interest* is sufficiently strong to overcome that right as a categorical matter. Thus, whether one deems the State's abstract interest in life an illegitimate basis for regulation -- as the *Cruzan* dissenters did -- or as a legitimate interest that justifies some state regulation -- as the Chief Justice's opinion in *Cruzan* did -- there is no basis for concluding that the State's abstract interest in life can justify entirely overriding patient choice. The interest simply does not outweigh the individual liberty at stake.

The premise that the State's abstract interest in life does not justify overriding individual autonomy does not in any way depend upon the supposed distinction between withdrawal of medical treatment and the prescription of life-ending medication. Whatever the merits of that distinction for other purposes, the State's abstract interest in life is identical in both cases. In either case, the state interest is in the preservation of life. Any measure that hastens the end of life, whether characterized as *action* or *inaction*, poses a threat to the State's abstract interest in life. Thus, the attempts by petitioners and their amici to characterize the right at stake in this case as involving "active" assistance simply have no relevance to the question whether the State's abstract interest in life overrides patient autonomy. That question was resolved in the negative by the course of reasoning in *Cruzan*, and the resolution there fully applies here.

This is not to say, however, that the State is powerless to take measures to further its abstract interest in life. As the joint opinion of Justices O'Connor, Kennedy, and Souter stated in *Casey:*

> Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed. Even in the earliest stages of pregnancy, the State may enact rules

> and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term and that there are procedures and institutions to allow adoption of unwanted children as well as a certain degree of state assistance if the mother chooses to raise the child herself.

505 U.S. at 872. So too may the State seek to ensure that a decision so momentous and irreversible as to forego even a short period at the end of life is a fully informed one. To this end, reasonable state laws that provide a framework in which this decision is made, should be upheld. Indeed, properly understood, *Cruzan's* approval of a heightened evidentiary threshold safeguards just such an interest -- ensuring that patient choice is in fact respected.

In the context of the present cases, the State can pursue its abstract interest in life by measures short of a total ban on patient choice. Proposals recently introduced in the legislatures in many States provide a variety of permissible means of addressing the State's legitimate concern that the patient himself or herself has given adequate attention to the sacredness of all life, and has considered the available alternatives. These proposals, which are summarized in Appendix A to this brief, include requirements that two financially independent physicians certify the patient's mental competence, that the patient make repeated statements of his or her wish to end life, that the patient be provided with information about treatment options, including palliative care, as well as other safeguards. This Court need not and should not hold that any of these particular provisions is constitutionally required to recognize that by removing *all choice* from patients, the New York and Washington laws go too far.

B. The State's Interest in Prevention of Suicide Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

Perhaps none of the arguments presented by petitioners and their amici has the same emotional appeal as the contention that affirming the decisions below would set the Court sliding down the

slippery slope to sanctioning suicide as a constitutional right. The claim is specious. Principles of judicial restraint counsel the Court to craft a narrow ruling in this case, one that addresses the facts before it, while leaving some line-drawing questions for another day.[11] Furthermore, even if the Court decides to tackle such questions here, affirming the judgments below in no way entails recognizing a general constitutional right to suicide. Indeed, examination of the state interest that justifies preventing suicide strengthens the conclusion that the cases before the Court present a very different question.

Apart from the State's abstract interest in life, the State's principal interest in preventing suicide is to preserve the actual life of persons who would otherwise commit suicide. The State may assume that a person who has not been diagnosed with a terminal illness will derive fulfillment from years of future life -- even if he or she does not presently realize this to be so. In preventing suicide by persons who are not terminally ill, the State seeks to protect the future self against the potentially rash judgment of the present self.

In contrast, a patient suffering from a terminal illness has no expectation of sustained future life. As a result, the State's interest in protecting the future self against the decision of the present self is greatly diminished. It is frankly grotesque for the State to justify overriding the patient's will on the ground that the patient would benefit from several weeks or months of physical deterioration or mental decomposition. The difference between preventing suicide generally and preventing a terminally ill patient from receiving a willing physician's aid in dying is the difference between a tolerable degree of paternalism in the interest of a person's enjoyment of life and what, from the perspective of the patient, can only be described as sadism.

"Liberty must not be extinguished for want of a line that is clear." *Casey*, 505 U.S. at 869. It certainly should not be extinguished because of imagined ambiguities that lie down a road

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[11] It is ironic that petitioners and their amici invoke the specter of judicial activism, while at the same time urging that the Court must issue a broad, categorical ruling. The charge of activism has been most deserved when the Court has reached out to decide questions not squarely before the Court. *See* Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. Rev. 1185 (1992). It is plain that in this case, petitioners and their amici seek a broad, categorical ruling, while respondents and their amici urge the Court to proceed with caution.

upon which this Court need never tread. The general state interest in preventing suicide has no bearing on the present cases.

C. The State's Interest in Preventing Coercion or Undue Influence Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

The State has a strong interest in preventing coercion or undue influence from being brought to bear on patients facing end-of-life decisions. Such pressure might come from health care providers seeking to redirect scarce medical resources and save on care costs or from family members who wish to spare themselves the emotional and financial drain of a loved one's protracted period of dying. These pressures justify state regulation to ensure that end-of-life decisions are made without coercion or undue influence.

Nevertheless, the risk of coercion is that a patient will be forced or pressured to choose a path that he or she would rather not choose. By seeking to enforce blanket prohibitions, petitioners would guarantee that in a large number of cases all choice is denied. Petitioners' proposed solution to the risk of coerced decisions -- removal of all decision making autonomy from the patient -- exacerbates the very problem it purports to solve.

The risks of coercion and undue influence are at least as great when a patient seeks to discontinue lifesaving medical care as when a patient seeks so-called *affirmative* aid. The same health professionals and family members face the same set of incentives when the patient's decision involves whether to discontinue medical treatment as they do when the patient's decision involves whether to seek a physician's aid in carrying out his or her decision to end life by other means.[12] Yet, as Petitioners concede, neither New

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[12] For example, the United States asserts that "[w]hen the choice is between suicide and an expensive and prolonged course of treatment, physicians may feel pressured to suggest the former." Brief for the United States as amicus curiae Supporting Petitioners at 24 (No. 96-110). Yet it is precisely such treatment that the United States and petitioners acknowledge that patients have a right to refuse, even when death will result. Similarly perplexing is the American Medical Association's concern that patients will seek aid in dying because they suffer from depression, *see* Brief of the American Medical Association, *et al.* at

York, Washington, nor any other State finds that these risks justify a ban on the discontinuation of lifesaving medical care, *see* Brief for the Petitioners at 12 (No. 96-110); Brief for Petitioners Vacco and Pataki at 11 (No. 95-1858) -- nor could they so find, given this Court's understanding in *Cruzan* that the risks of error must be carefully balanced.

Indeed, many States, including New York and Washington, permit the appointment of a surrogate to make life and death treatment decisions in the event the patient becomes incapacitated. *See* N.Y. Pub. Health Law §§ 2980-94 (McKinney 1993); Wash. Rev. Code Ann. § 11.94.010(3) (West Supp. 1996). When a patient has become incapacitated, the risk of a decision that reflects the interests of the surrogate or health care provider rather than the patient is at a maximum. In contrast, a mentally competent, terminally ill patient who seeks the assistance of a willing physician in carrying out his or her decision about how to live life's final days is in control of the decision making process in a way that cannot be true when a surrogate is required. By nonetheless allowing for surrogate decisionmaking in the event of incapacitation, the States recognize that the paramount interest in end-of-life decisions is ensuring that the patient's true wishes be carried out -- even when the risks of decisions based on other factors are substantially greater than when a mentally competent, terminally ill patient makes the ultimate decision.

Therefore, anecdotal evidence that permitting physicians to render aid in dying would lead doctors to pressure patients to end their lives, *see* Hendin, Seduced by Death: Doctors, Patients, and the Dutch Cure (1996), proves only that the States must have the authority to enact safeguards to ensure that a patient's decision is not the product of undue pressure. However, the state interest in preventing doctors from prescribing lethal medication to a patient who wishes to remain alive no more justifies a flat ban on such aid in dying than the identical state interest in preventing doctors from discontinuing lifesaving medical treatment against a patient's will would justify a blanket prohibition of patients' ability to discontinue such treatment.

In this context, regulation, as opposed to prohibition, is quite

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8-9 (No. 95-1858), given that patients are equally likely to refuse, or seek the withdrawal of, lifesaving treatment because they suffer from depression.

practical. As the eponymous respondent in No. 95-1858, Dr. Timothy Quill, has himself noted, the patient's right to make unencumbered decisions to die with dignity can be insulated from coercive pressure by requiring multiple requests, a healthy doctor-patient relationship, secondary consultation with another physician and clear documentation of the decision process. *See* Quill, *Care of the Hopelessly Ill*, 327 New Eng. J. Med. 1380 (1992). In addition, palliative care groups could be required to review patient requests and physician decisions to minimize the risk of abuse while ensuring access to the procedure when it is medically and ethically justified. Such a review program is particularly well-equipped to counter the threat of coercion by family members, doctors, or health maintenance organizations, because palliative-care review focuses on the condition and desires of the patient. *See* Miller, *et al.*, *Regulating Physician Assisted Death*, 331 New. Eng. J. Med. 119 (1994). *See also* Appendix A.

Thus the concern of petitioners and their amici that patients will seek a physician's aid in dying without exploring palliative care options is misplaced.[13] If anything, recognition of the right asserted here will require States to adopt more precise regulatory mechanisms, with the likely result that many patients who legally seek aid in dying will be required to contemplate palliative care options that, under existing law, they would not have considered.

The State may enact a wide variety of reasonable measures designed to ensure that the patient's decision reflects his or her will, free of coercion or undue influence. What the State may not do is deny all patient choice in the name of safeguarding unfettered choice. Yet that is precisely what the New York and Washington laws do.

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[13] In their focus on palliative care, petitioners and their amici obscure the fact that not all suffering experienced by terminally ill patients takes the form of physical pain. For many patients, the greater horror is the disintegration of their physical and mental capacities. To the extent that palliative care relies on sedation, it merely exacerbates the problem.

D. The State's Interest in Protecting the Handicapped and Other Disadvantaged Members of Society Does Not Justify an Outright Ban on Physicians Rendering Assistance to a Mentally Competent, Terminally Ill Patient in Carrying out his or her Decision About how to Live Life's Final Days.

Opponents of the right claimed here assert that the State has an interest in avoiding measures that will have the cumulative impact of devaluing the lives of persons with disabilities. *See, e.g.*, Brief Amici Curiae of the National Legal Center for the Medically Dependent & Disabled, Inc. at 9-11; Brief Amicus Curiae of the Catholic Medical Association at 15-16. In its strongest form, the argument goes as follows: in order to avoid enshrining a general right to suicide, the State must designate some conditions as qualifying persons for a right to physician assistance in ending life; the State thereby impliedly asserts that the quality and value of life for persons in the designated conditions is lower than for other persons; to avoid sending this message of inferiority, the State should avoid drawing such lines.

Whatever the force of the above argument, it is simply irrelevant to the cases now before the Court. The patients here (and the doctors who wish to assist them) all suffer from terminal illnesses. As noted above, the distinction between such patients and persons who do not suffer from a terminal illness has nothing to do with an assessment by the State (or a court) of the value of life. The point is that with death inevitable and imminent, the State's general interest in preventing suicide -- the interest in protecting a future self against the possibly rash judgment of the present self -- is greatly diminished. The Court need not and should not say in these cases that the State has some obligation to allow physician-assisted suicide for persons with some set of disabilities but not for other persons. The Court can and should affirm the rulings below without in any way implying such an obligation.

To the extent that petitioners also assert that persons with handicaps and other disadvantages deserve protection from undue pressure, of course we agree. The State has a strong interest in ensuring that the vulnerable are not pressured to seek physician assistance in ending life, just as it has a strong interest in ensuring that the vulnerable are not denied equal access to the right asserted here. *See Compassion in Dying*, 79 F.3d at 825 (observing that the

poor and minorities are more often under pressure *not to* exercise their rights, as in the case of abortion). For this reason, we support efforts to enact legislation that would ensure that mentally competent, terminally ill patients who seek a physician's aid in dying are not acting in response to financial or other undue pressure. The same measures that would limit the opportunities for coercion in general will provide protection for persons who are members of disadvantaged groups. *See* Appendix A.

E. The State's Interest in Maintaining the Ethical Integrity of the Medical Profession Does Not Justify an Outright Ban on Physicians Rendering Assistance to Mentally Competent Terminally Ill Patients in Carrying out Decisions About how to Live Life's Final Days.

In order to protect constitutional rights, this Court has not hesitated to strike down legislation that reflects a professional organization's view of the limits of acceptable behavior. *See, e.g., Bates v. State Bar*, 433 U.S. 350 (1977) (invalidating ban on attorney advertising). *Cf. Florida Bar v. Went For It, Inc.*, 115 S. Ct. 2371 (1995) (applying commercial speech test to state bar regulations). Thus, although the American Medical Association officially disapproved of abortion as late as 1967, *see Roe*, 410 U.S. at 142-43 (citing Proceedings of the AMA House of Delegates 40-51 (June 1967)), the *Roe* Court nonetheless recognized such a right. The fact that some or many members of a profession deem a particular practice inconsistent with their professional role is a valid reason why no professional should be *forced* to engage in that practice. It is not a reason why a professional who is willing to depart from the official position should be *prohibited* from following his or her conscience.

Accordingly, the objection that state-sanctioned physician aid in dying would convert doctors from healers into killers has no greater purchase here than does the parallel argument in the abortion context. No doctor should be required to render aid in dying to a patient who seeks the doctor's assistance, just as no doctor is required by *Roe* and *Casey* to perform an abortion.

The question whether a particular practice such as aid in dying is inconsistent with a doctor's professional role cannot be answered, as petitioners and their amici suggest, by definitional fiat. Here, the

willingness of a professional to assist the individual will facilitate the exercise of constitutional liberty. Under these circumstances, a professional organization cannot declare, as *ipse dixit*, that such assistance contravenes the professional role, and ask the Court to defer blindly to its unilateral judgment.

In fact, despite laws like those challenged here, and despite the reflexive opposition of the American Medical Association, opinion polls consistently show substantial support among doctors for the provision of aid in dying to mentally competent, terminally ill patients.[14] These doctors evidently understand the practice as consistent with their professional role. They believe that to deny the only form of relief they can render their terminally ill patients is an act of cruelty.

The argument that permitting doctors to perform abortions would lead to a devaluation of human life by the medical community was rejected by the *Roe* Court. There is no empirical support for the predicted devaluation. Indeed, the very fact that the American Medical Association appears now before the Court, with its professional integrity intact after 23 years of legalized abortion, making the very same argument rejected in *Roe*, merely underscores the flaw in the argument. The Association was wrong in its pre-*Roe* position, and it is wrong now.[15] Individual doctors can be trusted,

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[14]Jerald Bachman found that 54% of physicians favored legislation legalizing physician assistance for terminally ill, mentally competent adults. Bachman, *Assisted Suicide and Active Euthanasia in Michigan*, 331 New Eng. J. Med. 812 (1994). Jonathan Cohen polled 938 doctors in Washington and found that 54% supported physician assistance under certain carefully limited circumstances. Cohen, *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89 (1994). A poll of 740 Wisconsin doctors showed 42% supported a right of physician assistance for competent adults faced with severe illness and little chance of recovery. 28% of the Wisconsin sample said they would be willing to perform the procedure, Shapiro, *Willingness to Perform Euthanasia*, 154 Archives Internal Med. 575 (Mar. 14, 1994) (WL, AMA-JNLS database) (1994).

[15] The Association is also wrong in its assertion that regulations of the sort currently under consideration by the state legislatures would work an "unprecedented intrusion into the physician-patient relationship" and "would be fundamentally inconsistent with the private nature of health care treatment." Brief of the American Medical Association, *et al* at 17 (No. 96-110). The rise of managed care has already transformed the physician-patient relationship from the model the Association portrays. *See* Shaw, Letter: *Economics and the Examination Room: An Incident*, 347 Lancet 124-25 (1996).

subject to careful but reasonable regulation, to prescribe lethal medication to mentally competent, terminally ill patients who need assistance in carrying out their decisions about how to live life's final days.

IV. Affirming the Judgments Below Would Give Proper Recognition to the Principle that this Court Shares Responsibility with the State and Federal Legislatures for Striking a Balance Between Constitutional Rights and Government Regulation.

Petitioners and their amici attempt to tantalize this Court with the fool's gold of a decision avoided. Their argument takes the form of the question-begging trope that the Constitution is silent on the issue posed by these cases. The argument is bad in itself. Of course the text of the Constitution does not expressly mention aid in dying, any more than it expressly refers to flag-burning, discrimination on the basis of skin color, or a host of other practices that fall within the Constitution's general language. *See McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 407 (1819) (noting that the Constitution does not "partake of the prolixity of a legal code," and thus "only its great outlines should be marked").

Beyond its fundamental misapprehension of the nature of constitutional interpretation, the argument advanced by petitioners and their amici paints a vastly oversimplified picture of the reality the Court would face were it to reverse the judgments below. The Court would have to distinguish its commitment to even a very narrow version of the principle announced in *Cruzan*, namely that the Constitution affords protection to the right to refuse unwanted bodily intrusions, including means of respiration, nutrition and hydration. *See Cruzan*, 497 U.S. at 289 (O'Connor, J., concurring) ("the liberty guaranteed by the Due Process Clause must protect, if it protects anything, an individual's deeply personal decision to reject medical treatment, including the artificial delivery of food and water.").

To do otherwise, that is, to renounce the premise shared by eight Justices in *Cruzan* and expressly adopted by five Justices, would be to do irreparable harm to this Court's Due Process Liberty

jurisprudence. In *Casey*, this Court made clear that the right to choose an abortion free of undue government coercion encompasses the right to choose *not* to have an abortion free of government coercion. The Court stated that "*Roe* has been sensibly relied upon to counter any . . . suggestions" to the contrary. *Casey*, 505 U.S. at 859. In support of this proposition, the *Casey* Court cited a prominent decision of the New Jersey Supreme Court recognizing a right to refuse medical treatment. *See id.* (citing *In re Quinlan*, 70 N.J. 10, *cert. denied sub nom. Garger v. New Jersey*, 429 U.S. 922 (1976)).

Therefore, in order to maintain even the semblance of principled adjudication, a decision reversing the judgments below would have to explain why a right to refuse medical treatment receives constitutional protection but a right to the assistance of a willing physician in hastening death by other means does not. The Court would then be faced with the daunting task of defining the limits of the right to refuse treatment.

Suppose, for example, that a State were to forbid the withdrawal of a feeding tube or respirator in cases in which the patient initially consented to its insertion. Such withdrawal is an active measure that brings about death. Could the State decide that it is therefore not encompassed within the right to refuse treatment, or would it be obligated to treat the continued operation of the feeding tube or respirator as an ongoing invasion?

If a physician prescribes a mentally competent, terminally ill patient a lethal dose of painkillers in violation of state law, may the State use force -- for example, could the State pump the patient's stomach -- to counteract the effect of the drug? *Cf. Rochin v. California*, 342 U.S. 165 (1952). In other words, is the State free to act to restore the status quo that existed prior to the illegal act, or must it ignore the antecedent violation and avoid what would now constitute a bodily invasion?

In the practice known as "terminal sedation," a physician prescribes a sufficient quantity of sedative to induce coma, but does not then treat the accompanying depression of respiration or inability to ingest; as a result, the patient dies by asphyxiation, starvation or dehydration. *See Terminal Sedation in the Care of Dying Patients*, Archives Internal Med. (Sep. 9, 1996) (WL, AMA-JNLS database). Is this practice encompassed within the rubric of the right to refuse medical treatment, as the American Medical

Association contends? Brief of the American Medical Association, *et al* at 12-13 (No. 96-110).

Should the Court reverse the judgments below, there will be no way to avoid answering questions such as these. When such questions reach this Court, commitment to principled interpretation will require that they be faced. There is simply no way around the hard truth that difficult lines must be drawn, *regardless of how the Court rules in these cases.*

Nevertheless, as we have argued above, the Court need not attempt to resolve all of the difficult constitutional questions presented by state regulation of end-of-life decisions. It is sufficient to note here that the blanket bans of New York and Washington go too far. A ruling to that effect would properly place the matter in the hands of the state legislatures.

Although we do not endorse all of Judge Calabresi's creative proposal in the court below, *see Quill*, 80 F.3d at 738-43 (Calabresi, J., concurring) (arguing that the court should provisionally invalidate New York's statute and remand to the legislature for a statement of present support), we agree with the fundamental insight underlying his approach: a proper understanding of American constitutionalism recognizes that the judiciary and elected representatives share responsibility for interpreting foundational norms. This Court, along with the lower federal courts and state courts, must not hesitate to declare invalid laws that go beyond the proper bounds of legislative authority. At the same time, however, there is a substantial gray area in which elected bodies should be permitted to pursue legitimate governmental objectives that touch upon the exercise of constitutional rights. *See Casey*, 505 U.S. at 873 ("not every law which makes a right more difficult to exercise is, ipso facto, an infringement of that right.")

There exists a significant variety of measures that would protect the State's legitimate interests without unduly burdening the ultimate decision of a mentally competent, terminally ill patient to seek a willing physician's aid in dying. Many of these measures have been proposed as bills in the legislatures of the several States. *See* Appendix A. A ruling by this Court affirming the judgment below would in no way impair this ongoing legislative process. Quite to the contrary, a properly narrow ruling would send the signal to the state legislatures that where constitutional liberty is concerned, they cannot paint with an extremely broad brush; nor can

they use talismanic categories as a substitute for reasoned judgment. As legislators with a sworn duty to uphold the Constitution and an obligation to protect the interests of all persons subject to our laws, we would welcome such a signal.

Conclusion

For the foregoing reasons, the judgments of the Courts of Appeals for the Second and Ninth Circuits should be affirmed.

Respectfully submitted,

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Attorneys** for Amici Curiae

December 10, 1996

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* Counsel of Record

** We were assisted in the preparation of this brief by Columbia Law School students Stephen Gale Dick, Christian Halliburton and Daniel Spilo.

APPENDIX A

Recent Proposals and Enactments

This Appendix summarizes various proposals recently introduced for consideration in jurisdictions throughout the United States.

DEATH WITH DIGNITY PROPOSALS

At least eight States have considered adoption of similar legislation patterned after Oregon's "Death with Dignity Act," Or. Rev. Stat. §§ 127.800 *et seq* (1995). The current model state proposal differs in some respects from the Oregon statute, which is summarized separately below).

* **Status**: States in which the legislation has been proposed include the following:

- Arizona, S.B. 1007. Introduced January 8, 1996; to committee January 16, 1996.
- California, S.B. 1310 and A.B. 1080. Introduced February 23, 1995; died in committee, January 31, 1996.
- Colorado, H.B. 1185-96. Introduced January 1, 1996; referred to Committee; action postponed indefinitely, February 2, 1996.
- Maine, H.P. 552. Introduced March 7, 1995; House Committee on Judiciary votes not to recommend passage on June 14, 1995.
- Massachusetts, H.B. 3173. Introduced February 14, 1995.
- New Hampshire, H.B. 339. Introduced January 5, 1995; failed in House, January 4, 1996.
- Mississippi, H.B. 1023. Introduced January 22, 1996; died in committee February 6, 1996.
- Vermont, H.B. 335. Introduced February 21, 1995.

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication; authorize physician to prescribe lethal dose; set forth safeguards, procedures, immunities, and liabilities with respect to fulfilling such request; and make provision of aid in dying by hospital or physician voluntary. Would not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:
- Second opinion by qualified physician required as to diagnosis and prognosis required.

Consideration of Alternatives:
- Primary physician must discuss all feasible alternatives to aid in dying with patient.

Patient's Competence:
- Two physicians must confirm competence.
- Primary physician must refer patient to counseling if deemed necessary.

Voluntary and Informed Decision:
- Patient must make one written and two oral requests. Second oral request must be at least 15 days after written request. Physician must wait at least 48 hours after final oral request to write prescription.
- Before issuing prescription, physician must confirm that patient has made an informed request, and must offer patient opportunity to revoke request.
- Patient may revoke request at any time and in any manner.
- Requires two witnesses to patient's request; one witness shall not be related to or in a position to benefit from patient's death.

Prevention of Coercion:
- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be made contingent on patient's making request for aid in dying.
- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements
- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.
- Above information will not be available to public.
- State will conduct annual review of sample of records.

ADDITIONAL PROPOSALS AND ENACTMENTS

ALASKA -- H.B. 371:

* **Status**: Introduced January 8, 1996

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication, and authorize physician to prescribe lethal dose. Does not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:
- Second opinion by qualified physician required as to diagnosis and prognosis.

Consideration of Alternatives:
- Primary physician must discuss feasible alternatives to aid in dying and offer alternatives immediately prior to issuing prescription.

Patient's Competence:
- Two physicians must determine that patient is mentally competent.

Voluntary and Informed Request:
- Patient must make one written and one oral request, with 10-day waiting period between requests.
- Following oral request, physician must confirm that patient has made an informed decision and offer patient the chance to revoke the request.
- Patient may revoke request at any time in any manner.
- Two witnesses must attest that patient has made voluntary and informed decision. Neither witness can: be related by blood; entitled to a portion of the patient's estate; have a creditor's claim against patient or estate; be the patient's physician or employed by the patient's health care provider.

Prevention of Coercion:
- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be altered or made contingent on patient's making request for aid in dying.
- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements
- Patient's medical records must include documentation of compliance with all safeguards.

CALIFORNIA -- GUIDELINES OF THE BAY AREA NETWORK OF ETHICS COMMITTEES

* **Summary**: The Bay Area Network of Ethics Committees has prepared "Guidelines for Comprehensive Care of the Terminally Ill," including provisions on aiding terminally ill patients to hasten their death. The guidelines acknowledge the difficulty in treating patients facing protracted, painful terminal illness and difficult decisions regarding end-of-life care. The guidelines urge primary care physicians to consider referrals to appropriate hospice programs and/or consultation with physicians experienced in palliative care. When the patient has requested a physician's aid in dying, the group recommends extensive safeguards and quality-of-care guidelines, summarized below.

* **Safeguards**:

Diagnosis
- Physician should obtain second opinion on terminal diagnosis.

Mental Competence
- Physician should confirm that patient is competent and obtain a second opinion as to competence.
- Physicians are urged to seek appropriate aid from other practitioners in medical and mental health communities.

Consideration of Alternatives
- Physician should ensure that patient has access to palliative care.
- Documentation of patient's evaluation by hospice program or palliative care specialist, or of patient's decision to decline such care.

Voluntary and Informed Decision
- Physician should urge patient, where appropriate, to consult family members and other affected parties in making end-of-life decisions.
- Patient should sign two witnessed statements that decision is voluntary and informed. The second should be executed at least 48 hours after the first. Both should be signed before two witnesses who are unrelated to patient and in no position to benefit from patient's death.

- Physician should ensure that patient is aware that request is revocable at any time.

Documentation
- Before writing prescription, physician should confirm that all of the above have been duly documented.

MARYLAND -- H.B. 474

* **Status**: Introduced January 31, 1996.

* **Summary**: Would, *inter alia*, allow a mentally competent adult suffering from painful terminal condition to request aid in dying, set forth procedures and safeguards for carrying out such request, and make participation in aid in dying optional for physicians and hospitals.

* **Safeguards**:

Confirmation of Diagnosis:
- Diagnosis of painful fatal condition by two physicians; physicians may not be partners or shareholders in the same medical practice (except as members of the same HMO).

Consideration of Alternatives:
- Physician must determine that passive withdrawal of life-sustaining medical support or withholding of nutrition and hydration will not alleviate suffering.

Patient's Competence:
- Physician must determine that patient request is not the result of clinical depression.
- Physician may refer patient to counseling if appropriate.

Voluntary and Informed Decision:
- Patient must make three requests, including one written request.
- Requires waiting period of two weeks between first and final requests.
- Request is revocable at any time without regard to mental capacity.

Autnenticity of Request:
- Two witnesses to written request must attest that patient appears to be competent and acting voluntarily.

Prevention of Coercion:
- Insurance benefits and health care services may not be made contingent on execution of execute aid-in-dying request.
- Misdemeanor penalties for persons who forge, alter, conceal, or procure through undue influence or coercion an aid in dying

request or revocation of such request.

MICHIGAN -- H.B. 4134:

* **Status**: Introduced, January 17, 1996.

* **Summary**: Would allow qualified patients to make revocable request for aid in dying, defined here as "provision of a lethal agent;" create judicial review of aid-in-dying requests and revocations; create immunities for those who provide aid-in-dying.

* **Safeguards**:

Diagnosis:

- Two physicians must confirm diagnosis.

Consideration of Alternatives:

- Two physicians and one qualified mental health counselor must discuss treatment options with patient.

Patient's Competence:

- Primary physician and psychologist or other physician must determine mental competence.

Voluntary and Informed Decision:

- Qualified counselor must discuss with patient motivations for aid-in-dying request. Three-day waiting period between counseling and provision of aid in dying.
- Written and oral request required, with 15-day waiting period between requests.
- Patient may revoke request at any time and in any manner.

Prevention of Coercion:

- Declares void any contract provision, including insurance plans and wills, that are contingent on execution of aid-in-dying requests; prohibits insurers from refusing coverage, altering policy terms or invoking exemptions on the basis of aid-in-dying requests.
- Felony punishment for forgery, fraudulent inducement or coercion with respect to aid in dying request, or concealment or destruction of revocation of such request, resulting in death.

Additional Safeguards:

- Creates cause of action for specified relatives to clarify status of patient's request, and requires expedited consideration of such actions;
- Allows health facilities to create additional safeguards, and makes provision of aid in dying by health facilities and physicians voluntary.

NEW YORK -- S.B. 5024; [S.B. 1683; A.B. 6333]

* **Status**:

- S.B. 5024: Introduced on May 3, 1995; in Senate Committee on Health as of 1/3/96.
- S.B. 1683: Introduced February 1, 1995.
- A.B. 6333: Introduced on April 22, 1995.

* **Summary**: Would allow competent adult suffering from terminal illness to request self-administered lethal dosage of medication; authorize physician to prescribe lethal dose; establish safeguards and record-keeping procedures for fulfilling aid-in-dying requests; and make provision of aid in dying by hospital or physician voluntary. Does not authorize active euthanasia, lethal injection, or mercy killing.

* **Safeguards**:

Confirmation of Diagnosis:

- Second opinion by qualified physician required as to diagnosis and prognosis required.

Consideration of Alternatives:

- Primary physician must discuss all feasible alternatives to aid in dying with patient.

Patient's Competence:

- Two physicians must confirm competence.
- Primary physician must refer patient to counseling if deemed necessary.

Voluntary and Informed Decision:

- Patient must make one written and two oral requests, with at least 15 days between written request and final oral request. Physician must wait at least 48 hours after final oral request to issue prescription.
- Before issuing prescription, physician must confirm that patient has made an informed request, and must offer patient opportunity to revoke request.
- Patient may revoke request at any time and in any manner.
- Two witnesses, one of whom shall not be related to or in a position to benefit from patient's death, must confirm that patient appears to be competent and acting voluntarily.

Prevention of Coercion:

- Provisions in wills and other contracts, as well as insurance and annuity coverage and benefits, cannot be made contingent on patient's making request for aid in dying.

- Criminal penalties when any of the following result in patient's death: forgery or alteration of request for medication, concealment or destruction of revocation of request, or coercion or undue influence on patient to request medication.

Recording Requirements

- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

OREGON -- Or. Rev. Stat. §§ 127.800 *et seq.* (1995)

* **Summary**: Allows competent adult diagnosed with terminal illness to make voluntary, informed request for medication to end his or her life; specifies the form of written request; and sets forth safeguards, procedures, immunities, and liabilities with respect to honoring such request; administration of request for lethal medication is voluntary for health care providers and organizations.

* **Safeguards**:

Diagnosis:

- Diagnosis of terminal illness must be made by two physicians.

Consideration of Alternatives:

- Attending physician must discuss feasible alternatives, including comfort care and pain control, with patient.

Patient Competence:

- Determination of mental competence must be made by two physicians;
- Attending and consulting physician each under duty to refer patient to counseling if deemed necessary.

Voluntary Decision:

- Physicians must confirm that patient's decision is voluntary when making diagnosis and immediately prior to issuing prescription.
- Two witnesses, one of whom may not be related to patient by blood, entitled to a portion of patient's estate, or an owner or employee of facility treating patient, must attest that patient is acting voluntarily.
- Patient must make one written and two oral requests, with at least 15 days between written request and final oral request. Physician must wait at least 48 hours after final oral request to

issue prescription.

- Patient may rescind request at any time and in any manner, without regard to mental state.
- Physician must offer patient opportunity to rescind request before writing prescription.

Coercion

- Provisions in contracts or wills that would affect a person's decision whether to make or rescind a request under this statute are invalid.
- No contractual obligations, insurance or annuity policies can be conditioned or affected by making or rescission of request.
- Forgery or alteration of request for medication, and concealment or destruction of rescission of such request, with intent or effect of causing death, is a felony.
- Coercion or undue influence with respect to request or rescission, with intent or effect of causing death, is a felony.

Recording Requirements

- Patient's medical file must include documentation of: all oral and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

RHODE ISLAND -- S. 2985.

* **Status**: Introduced February 6, 1996.

* **Summary**: Would authorize physicians to help competent adults suffering from terminal or intractable and unbearable illness to obtain the medical means of suicide, and to assist patient in administration of such means.

* **Safeguards**:

Confirmation of Diagnosis:

- Second opinion required as to diagnosis and prognosis.

Consideration of Alternatives

- Physician must offer alternative treatments, including palliative or hospice care, as well as counseling, and must discuss thoroughly diagnosis and prognosis.

Patient's Competence:

- Written opinion from qualified mental health professional as to patient's competence.

Voluntary and Informed Decision
- Requires two requests by patient, at least 14 days apart; second request must be no more than 72 hours before physician provides patient with medical means of dying.
- Consulting physician and mental health professional must confirm in writing that patient is acting voluntarily.
- Witness must confirm that physician has presented patient with information concerning treatment options and that patient is acting voluntarily.

Prevention of Coercion
- Prohibits insurers, health plans and providers from making services or benefits contingent on request for physician-assisted suicide. Patient's use of aid in dying will not be deemed suicide for insurance purposes.

Recording Requirements
- Patient's medical records must include documentation of compliance with all safeguards.

WASHINGTON -- S.B. 5596

* **Status**: Introduced January 27, 1995.

* **Description**: Would allow a competent, terminally ill adult to make a voluntary, revocable request for physician to prescribe lethal dose of medication to be self-administered by patient; authorize health care providers to participate in aid-in-dying requests.

* **Safeguards**:

Diagnosis:
- Two physicians must independently agree on diagnosis.

Consideration of Alternatives
- Both primary and consulting physician must discuss with patient feasible alternatives to aid in dying.
- Immediately prior to issuing prescription, physician must confirm that patient has been offered all treatment alternatives.

Patient Competence
- Consulting physician to make independent determination of competence

Voluntary and Informed Decision
- Request must be made in writing or on videotape in the presence of two witnesses, neither of whom is related to patient or stands to benefit from patient's death.
- Request for aid in dying may be revoked at any time through

various means.
- Insurance and health plan coverage, benefits and treatment cannot be made contingent upon request for aid in dying.
- Undue influence upon patient to request aid in dying, including through persuasion that patient is financial or emotional burden, punishable as misdemeanor or, if death results, as felony.
- Fraud, forgery, or falsification as to aid in dying request, and concealment or destruction of revocation of such request, punishable as misdemeanor or, if death results, as felony.

WISCONSIN -- A.B. 174, S.B. 90

* **Status**: Introduced April 2, 1995.

* **Summary**: Permits competent adults suffering from terminal illness to make voluntary request for medication to end life.

* **Safeguards**:

Diagnosis:
- Second opinion required as to diagnosis and prognosis.

Consideration of Alternatives:
- Physician must inform patient of feasible alternatives.

Patient's Competence
- Physician must refer patient for counseling if deemed appropriate by either primary or consulting physician.

Voluntary Nature of Request
- Patient must make three requests: an oral request, followed at least 15 days later by a written request, followed by a second oral request. At least 48 hours must elapse between final request and issuance of prescription.
- Patient may revoke request at any time in any of several specified ways.
- Three witnesses, none related by blood, entitled to a portion of patient's estate, or financially responsible for patient's health care.

Prevention of Coercion
- Criminal penalties for forgery or falsification of aid-in-dying request, or concealment of knowledge of rescission of such request.
- Patient may not be required to make an aid-in-dying request as a condition for receipt of health care.

Recording Requirements
- Patient's medical file must include documentation of: all oral

and written requests; determination by two physicians of patient's diagnosis, prognosis, and competence, and the voluntary nature of the request; counseling sessions; and the physician's offer to rescind patient's request.

APPENDIX B

List of *Amici*

Name	State
Representative Kay Brown	Alaska
Representative John Davies	Alaska
Senator Johnny Ellis	Alaska
Representative David Finkelstein	Alaska
Representative Cynthia Toohey	Alaska
Senator Peter Goudinoff	Arizona
Representative Peggy Lamm	Colorado
Senator George Jepsen	Connecticut
Representative Mike Lawlor	Connecticut
Senator Edith Prague	Connecticut
Representative Wendy Jaquet	Idaho
Representative Sara Feigenholtz	Illinois
Representative Barbara Flynn Currie	Illinois
Representative Fred Richardson	Maine
Representative Barbara Dobb	Michigan
Representative Jan Dolan	Michigan
Representative Susan Grimes-Munsell	Michigan

Senator Ernie Chambers	Nebraska
Senator Liz Stefanics	New Mexico
Senator Franz Leichter	New York
Senator Ron C. Cease	Oregon
Representative Edith Ajello	Rhode Island
Representative David Cicilline	Rhode Island
Senator Rhoda Perry	Rhode Island
Senator John Roney	Rhode Island
Senator Charles Walton	Rhode Island
Representative Alan Bjerke	Vermont
Representative Lynn Bohi	Vermont
Representative Dean Corren	Vermont
Senator Jeanne Kohl	Washington
Representative Ed Murray	Washington
Representative Helen Sommers	Washington
Senator Pat Thibaudeau	Washington
Representative Georgette Valle	Washington
Representative Tammy Baldwin	Wisconsin
Senator Fred Risser	Wisconsin

(51) (55)

Nos. 95-1858 and 96-110

Supreme Court, U.S.
FILED
DEC 10 1996
CLERK

In The

Supreme Court of the United States

October Term, 1996

DENNIS C. VACCO, *et al.*,
Petitioners,
v.
TIMOTHY E. QUILL, M.D., *et al.*,
Respondents.

STATE OF WASHINGTON, *et al.*,
Petitioners,
v.
HAROLD GLUCKSBERG, M.D., *et al.*,
Respondents.

On Writ of Certiorari to the United States Courts of Appeals for the Second and Ninth Circuits

BRIEF AMICI CURIAE SUPPORTING RESPONDENTS OF THE AMERICAN CIVIL LIBERTIES UNION, AMERICAN CIVIL LIBERTIES UNION OF WASHINGTON, NATIONAL GRAY PANTHERS PROJECT FUND, (continued on back of cover)

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TABLE OF CONTENTS

Page

INTERESTS OF AMICI CURIAE 1

SUMMARY OF ARGUMENT 1

ARGUMENT 2

I. THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS THE PERSONAL CHOICE OF A MENTALLY COMPETENT, TERMINALLY ILL INDIVIDUAL TO END UNENDURABLE SUFFERING AND HASTEN INEVITABLE DEATH 2

A. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Deeply Rooted in this Nation's History and Tradition 4

B. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Implicit in the Concept of Ordered Liberty 9

II. A BLANKET PROHIBITION AGAINST AID TO SUICIDE UNDULY BURDENS THE RIGHT OF THE TERMINALLY ILL TO MAKE RATIONAL END OF LIFE DECISIONS 14

A. A Blanket Ban on Assistance to Suicide Is a Substantial Obstacle to the Right of the Terminally Ill to End Their Suffering. 15

B. The States' Asserted Interests Do Not Justify an Absolute Ban on Physician Aid in Dying for the Terminally Ill 17

1. Interest in Preserving Each Citizen's Life 17

TABLE OF CONTENTS — Continued

Page

2. Preventing Undue Influence or Mistake 19

3. Implicating Doctors in Killing and Slippery-Slope Arguments 22

III. BECAUSE TERMINALLY ILL PATIENTS ON LIFE SUPPORT HAVE THE RIGHT TO MEDICAL ASSISTANCE IN HASTENING DEATH, DENYING TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT MEDICAL ASSISTANCE IN HASTENING DEATH VIOLATES THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT . . 24

CONCLUSION 29

TABLE OF AUTHORITIES

CASES

Page

Compassion In Dying v. *Washington*, 79 F.3d 790 (9th Cir. 1996) . . . . . passim

Cruzan v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990) . . . . . passim

Daniels v. *Williams*, 474 U.S. 327 (1986) 2

Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 10

Estelle v. *Gamble*, 429 U.S. 97 (1976) 12

Griswold v. *Connecticut*, 381 U.S. 479 (1965) 10

Hudson v. *McMillian*, 503 U.S. 1 (1992) 12

Ingraham v. *Wright*, 430 U.S. 651 (1977) 12

Jacobson v. *Massachusetts*, 197 U.S. 11 (1905) 11, 12

Loving v. *Virginia*, 388 U.S. 1 (1967) 10

Moore v. *City of East Cleveland*, 431 U.S. 494 (1977) 3, 10, 15

Palko v. *Connecticut*, 302 U.S. 319 (1937) 3

Parham v. *J.R.*, 442 U.S. 584 (1979) 12

Planned Parenthood of Southeastern Pennsylvania v. *Casey*, 505 U.S. 833 (1992) . . . . . passim

Poe v. *Ollman*, 367 U.S. 497 (1961) 3

Prince v. *Massachusetts*, 321 U.S. 158 (1944) 10

TABLE OF AUTHORTIES — Continued

Page

Quill v. *Vacco*, 80 F.3d 716 (2d Cir. 1996) . . . . . passim

Rochin v. *California*, 342 U.S. 165 (1952) 3, 11

Roe v. *Wade*, 410 U.S. 113 (1973) 4, 10

Royster Guano Co. v. *Virginia*, 252 U.S. 412 (1920) 24

Schmerber v. *California*, 384 U.S. 757 (1966) 11

Vitek v. *Jones*, 455 U.S. 480 (1980) 12

Washington v. *Harper*, 494 U.S. 210 (1990) 11, 12

Winston v. *Lee*, 470 U.S. 753 (1985) 11

Wooley v. *Maynard*, 430 U.S. 705 (1977) 18

STATUTES

N.Y. Pub. Health Law §§ 2960 et seq. (McKinney 1993) . . 19

N.Y. Pub. Health Law § 2981 (McKinney 1993) 19

Or. Rev. Stat. §§ 127.800-127.995 (1995) 22

U.S. Const. Amend. XIV 2

MISCELLANEOUS

Aristotle's Politics 5

M. Babst Battin & David J. Mayo, *Suicide: The Philosophical Issues* (1980) 5, 6, 8

TABLE OF AUTHORTIES — Continued

Page

Howard Brody, *Assisted Death — A Compassionate Response to Medical Failure*, 327 New Eng. J. Med. 1385 (1992) 13

Maria T. CeloCruz, Note, *Aid-In-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369 (1992) 6

Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* (1993) 14

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Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021 (1992) . . 7

Sherman B. Nuland, *How We Die* (1993) 5

TABLE OF AUTHORTIES — Continued

Page

Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. Times, Nov. 1, 1994, at A27 27

Julia Pugliese, Note, *Don't Ask Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1290 (1993) 8

Timothy G. Quill, *Death and Dignity: A Case of Individualized Decision-making*, 324 New Eng. J. Med. 691 (1991) 8, 16

O.R. Russell, *Freedom to Die* (1975) 6

The Republic of Plato (Alan Bloom ed. 1968) 5

Catherine D. Shaffer, Note, *Criminal Liability for Assisted Suicide*, 86 Colum. L. Rev. 348 (1986) 7

Jeff Stryker, *A Bedside Manner for Death and Dying*, N.Y. Times, May 19, 1996, § 4, at 3 7

Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y. L. Sch. L. Rev. 439 (1992) 5

INTERESTS OF AMICI CURIAE

The interests of amici curiae are set forth in the appendix to this brief.[1]

SUMMARY OF ARGUMENT

At issue in this case is no more and no less than (1) whether a mentally competent, terminally ill person suffering intolerably has a liberty interest protected by the Fourteenth Amendment in choosing to hasten the timing of an inevitable death, (2) whether a state's interests can justify a blanket prohibition on physicians providing assistance in the exercise of such a liberty interest, if it so exists, and (3) whether a state can justifiably grant certain persons the opportunity to make the choice to hasten death while denying to other, similarly situated persons the same opportunity.

The right of a competent, terminally ill person to avoid excruciating pain and embrace a timely and dignified death bears the sanction of history and is implicit in the concept of ordered liberty. The exercise of this right is as central to personal autonomy and bodily integrity as the exercise of rights safeguarded by this Court's decisions relating to marriage, family relationships, procreation, contraception, child rearing and the refusal or termination of life-saving medical treatment. In particular, this Court's recent decisions concerning the right to refuse medical treatment and the right to abortion instruct that a mentally competent, terminally ill person has a protected liberty interest in choosing to end intolerable suffering by hastening his or her own death.

A state's categorical ban on physician assistance to suicide — as applied to competent, terminally ill patients who wish to avoid unendurable pain and hasten inevitable death — substantially interferes with this protected liberty interest and cannot be sustained. Though a state has significant interests in ensuring that the right at issue here is not abused or misused, an absolute ban on physician assistance unduly burdens the proper exercise of the right of the terminally ill to seek freedom from pain through death, especially given the less restrictive alternatives that are

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[1] Letters of consent to the filing of this brief have been lodged with the Clerk of the Court pursuant to Rule 37.3.

available to a state and that would in fact greater serve its claimed interests.

Indeed, states typically and successfully employ less restrictive alternatives than blanket prohibitions for terminally ill patients depending on life-sustaining treatment who wish to hasten death. States have recognized the right of this class of terminally ill patients to escape pain and hasten death through the termination or refusal of such life support and accompanying administration of large and lethal doses of pain-suppressing medication. Accordingly, a state denies equal protection of its laws when it provides that one class of persons may exercise this right while others who are similarly situated for all relevant purposes are wholly denied the opportunity to exercise the same right for the same reason.

ARGUMENT

I.

THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT PROTECTS THE PERSONAL CHOICE OF A MENTALLY COMPETENT, TERMINALLY ILL INDIVIDUAL TO END UNENDURABLE SUFFERING AND HASTEN INEVITABLE DEATH

The Due Process Clause of the Fourteenth Amendment declares that no State shall "deprive any person of life, liberty, or property, without due process of law." U.S. Const. Amend. XIV. The Due Process Clause has long been held to contain a substantive component forbidding certain government actions regardless of procedural fairness. See *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833, 846 (1992); *Daniels* v. *Williams*, 474 U.S. 327, 331 (1986).

The content of substantive due process — *i.e.*, the constitutionally protected interests comprehended within the term "liberty" — cannot be determined by easy reference to any rule, text or historical period. "Neither the Bill of Rights nor the specific practices of States at the time of the adoption of the Fourteenth Amendment marks the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." *Casey*, 505 U.S. at 848. In the words of Justice Harlan,

> the full scope of the liberty guaranteed by the Due Process Clause cannot be found in or limited by the precise terms of the specific guarantees elsewhere provided in the Constitution.... It is a rational continuum which, broadly speaking, includes a freedom from all substantial arbitrary impositions and purposeless restraints.

Poe v. *Ollman*, 367 U.S. 497, 543 (1961) (Harlan, J., dissenting). Accordingly, in determining the reach of the "least specific and most comprehensive protection" that is the Fourteenth Amendment's guarantee of liberty, courts must employ considered reason and remain "duly mindful of reconciling the needs both of continuity and of change in a progressive society." *Rochin* v. *California*, 342 U.S. 165, 170, 172 (1952); see also *Casey*, 505 U.S. at 847-49 (courts must employ "reasoned judgment" to determine the scope of that "realm of personal liberty which the government may not enter").

Although the boundaries of substantive due process "are not susceptible of expression as a simple rule," *Casey*, 505 U.S. at 849, this Court has articulated two basic lines of inquiry for deciding whether a particular right falls within the liberty provision of the Due Process Clause. First, the Court has looked to whether the asserted right is "deeply rooted in this Nation's history and tradition." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977). Second, the Court has consulted the present conscience of the people to determine whether the asserted right is "implicit in the concept of ordered liberty," such that "neither liberty nor justice would exist if [it] were sacrificed." *Palko* v. *Connecticut*, 302 U.S. 319, 325-26 (1937).

In this case, either line of inquiry leads to the conclusion that a mentally competent, terminally ill person's decision to escape unendurable suffering by choosing to die is entitled to recognition as a constitutionally protected liberty interest. That is, the right of the terminally ill to find relief from excruciating pain by hastening death bears the sanction of history. It is also entirely consistent with other rights of fundamental personal autonomy that this Court has found "implicit in the concept of ordered liberty" and thus embraced by the Fourteenth Amendment's Due Process Clause.

A. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Deeply Rooted in this Nation's History and Tradition.

Petitioners and their supporting amici contend that history and tradition support their position, but in doing so they improperly define the practice at issue here. Although history's view of suicide generally is subject to debate, this case presents only the narrow question of whether a mentally competent, terminally ill person has a right to seek an end to intolerable suffering by hastening an inevitable death.[2] Framed in these terms, the historical analysis appears very different. In fact, there is a strong historical tradition accepting, and often honoring, terminally ill persons who choose a timely and dignified death in the face of unrelenting and unendurable suffering.

This tradition traces back at least as far as the Greek and Roman philosophers, who accepted suicide where necessary to achieve a dignified death and to escape from a terminal and incapacitating disease.[3] For example, Plato's *Republic* sanctioned a choice to die under such circumstances: "If any man labour of an

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[2] The complaint in the case from Washington asserted the issue in terms of whether the "Fourteenth Amendment protects the rights of terminally ill adults with no chance of recovery to make decisions about the end of their lives, including the right to choose to hasten inevitable death with suitable physician-prescribed drugs and thereby avoid pain and suffering." Pet. App. A17 n.7. The first paragraph of the complaint describing the nature of the action brought in New York asserted the issue in the same terms.

As the Ninth Circuit noted, following the approach of this Court's abortion decisions, the liberty interest at stake is not the right to *assistance* with suicide but, rather, the right of the terminally ill to hasten their death. If such a right exists, then the inquiry is whether a complete ban on assistance in exercising this liberty interest constitutes an undue burden. See *Compassion In Dying* v. *Washington*, 79 F.3d 790, 801-02 (9th Cir. 1996).

[3] This Court has considered the moral tradition of the Greeks in assessing other liberty interests. See *Roe* v. *Wade*, 410 U.S. 113, 130-32 (1973).

incurable disease, he may dispatch himself, if it be to his good."[4] Similarly, the Stoics of Rome, who believed that freedom must be based on the dictates of the deliberative will rather than passion or compulsion, embraced suicide as an appropriate response to a terminal illness whose overpowering physical assaults and demands would otherwise superimpose itself on the will and usurp the freedom of the sufferer.[5]

Significantly, neither the Old nor the New Testament prohibits suicide.[6] The notion of suicide as a crime was not introduced until late in Christian doctrine, and then only as a response to the temptation that martyrdom held for the early Christians.[7] Moreover,

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[4] *The Republic of Plato* Book III, 406a-409 (Alan Bloom ed. 1968). Aristotle, too, endorsed this possibility in his *Politics*. See *Aristotle's Politics* III, vi, 1278b15-30

[5] See Patricia A. Unz, Note, *Euthanasia: A Constitutionally Protected Peaceful Death*, 37 N.Y.L. Sch. L. Rev. 439, 441-42 (1992). Writing in this tradition, Seneca, the great Roman orator, stated:

> I will not relinquish old age if it leaves my better part intact. But if it begins to shake my mind, if it destroys its faculties one by one, if it leaves me not life but breath, I will depart from the putrid or tottering edifice. I will not escape by death from disease so long as it may be healed, and leaves my mind unimpaired. I will not raise my hand against myself on account of pain, for so to die is to be conquered. But I know if I must suffer without hope of relief, I will depart, not through fear of the pain itself, but because it prevents all for which I would live.

Quoted in Sherman B. Nuland, *How We Die* 151 (1993).

[6] None of the four suicides recorded in the Old Testament — Samson, Saul, Abimelech and Achitophel — is criticized. See Alfred Alvarez, "The Background" 12, *in* M. Babst Battin & David J. Mayo, *Suicide: The Philosophical Issues* (1980). The New Testament (Matthew) records the suicide of Judas Iscariot perfunctorily, "instead of being added to his crimes, it seems a measure of his repentance." *Id.* "In the first years of the Church, suicide was such a neutral subject that even the death of Jesus was regarded by Tertullian, one of the most fiery of the early Fathers, as a kind of suicide." *Id.*

[7] The Christian church taught that the world was a vale of tears, sin and temptation, from which death would release the faithful into eternal glory. Martyrdom afforded certain redemption, and the names of early martyrs were celebrated and their relics worshiped. The temptation to martyrdom culminated in the frenzy of the Donatists who, in the fourth and fifth centuries, actively pursued death. In response, St. Augustine argued in his writings that suicide was a sin.

despite the Church's general prohibition on suicide, certain prominent adherents recognized the appropriateness of choosing death as a means to end intolerable suffering for the terminally ill. Sir Thomas More, who was later canonized by the Roman Catholic Church, strongly supported the right of those with incurable diseases to commit suicide, and in *Utopia* he depicted the ideal treatment of the terminally ill, "full of continual pain and anguish," as allowing the patient to "despatch himself out of that painful life, as out of a prison."[8]

The origin of suicide as an English common law offense was also ecclesiastical; thus, the initial penalty was merely the denial of a Christian burial.[9] During feudal times, the penalty was expanded to include the forfeiture of goods to the suicide's liege lord; later, the Crown declared suicide a felony, primarily because a felon's goods were then forfeited directly to the King.[10] The common law, however, has never treated all suicides alike. Of greatest significance here, it was more lenient from the outset with those who killed themselves due to an inability to endure the suffering of disease.[11]

The crime of suicide, along with the rest of English common law, migrated to the American colonies, but it never took root even in its more limited form. As the Ninth Circuit explained: "There is no evidence that any court ever imposed a punishment for suicide or attempted suicide under common law in post-revolutionary America. By the time the Fourteenth Amendment was adopted in 1868, suicide was generally not punishable, and in only nine of the

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These arguments, coupled with the example of the Donatists, convinced the Church to legislate against suicide. See *id.* at 25-28.

[8] Quoted in O.R. Russell, *Freedom to Die* 55-56 (1975).

[9] See Maria T. CeloCruz, Note, *Aid-In-Dying: Should We Decriminalize Physician-Assisted Suicide and Physician-Committed Euthanasia?*, 18 Am. J.L. & Med. 369, 373 (1992).

[10] *Id.* at 373-74.

[11] See *Compassion*, 79 F.3d at 808-09 (citing 2 H. de Bracton (c. 1250) reprinted in *On the Laws and Customs of England* 423 (S. Thorne trans., 1968)).

37 states is it clear that there were statutes prohibiting assisting suicide." *Compassion In Dying* v. *Washington*, 79 F.3d 790, 809 (9th Cir. 1996).

Today, no American jurisdiction criminalizes suicide or attempted suicide. And while a small majority of states currently criminalize assistance to suicide, there is no reported American case of a physician criminally punished for helping a patient commit suicide notwithstanding the fact that assisting the terminally ill who wish to hasten their deaths has been a time-honored, though hidden, practice of compassionate physicians.[12] For well over the past half century, no person (physician or otherwise) has been meaningfully punished for aiding the terminally ill to end their suffering.[13] This reluctance to prosecute and failure to punish can only be explained by society's abiding judgment that it has no right to insist on the continued suffering of the terminally ill, and no right to punish those who honor the request of the terminally ill by assisting them in ending their agony.[14]

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[12] See *id.* at 811 & nn.56-59; see also Note, *Physician-Assisted Suicide and the Right to Die with Assistance*, 105 Harv. L. Rev. 2021, 2021 n.7 (1992).

[13] "[F]rom 1930 to 1985, not one state court decision on an actual prosecution for suicide assistance appears in an official state reporter." Catherine D. Shaffer, Note, *Criminal Liability for Assisted Suicide*, 86 Colum. L. Rev. 348, 358 (1986). Based on newspaper and wire service accounts, it appears that such cases either have not been prosecuted or have resulted in acquittal or sentences of probation. See *id.* In the last decade, of course, there have been several well-publicized prosecutions. All, so far, have resulted in jury acquittals. See Jeff Stryker, *A Bedside Manner for Death and Dying*, N.Y. Times, May 19, 1996, § 4, at 3.

[14] Indeed, to argue that suicide by persons suffering from terminal illness is ethically wrong, philosophers and theologians have had to resort to the concept of God's proprietary claim over his creations. John Locke argued that suicide was a crime because man does not have absolute dominion over himself; his being belongs to God and he thus has no right to destroy it. "[M]en being the workmanship of one omnipotent ... makes all servants of one sovereign master, sent into the world by his order and about his business — they are his property, whose workmanship they are, made to last during his, not another's pleasure." John Locke, *The Second Treatise of Government* 9, 17, 21 (C.B. Macpherson ed. 1980). The theologian, Dietrich Bonhoeffer, has similarly stated: "It becomes quite clear that a purely moral judgment on suicide is impossible, and indeed that suicide has nothing to fear from an atheistic ethic. The right to suicide is nullified

There is nothing new about the desire of terminally ill patients to end their suffering by hastening death. Developments in modern health care have simply brought into the open a previously private practice that society has long condoned. Until the early part of this century, patients suffering from incurable conditions overwhelmingly died at home due to the limitations of the health care system. Their deaths were frequently eased by the ministrations of alcohol and opiates.[15] Indeed, opiates (including morphine), which lead to death in excessive doses, were available without prescription until 1914. Thus, terminally ill patients had at their disposal throughout the Nation's early history the means of hastening death in a certain and gentle manner when their pain became unendurable.

With the regulation of morphine and other opiates during the last century, this gentle quitting of a life ravaged by terminal disease became dependent on the aid of compassionate physicians. The evidence shows that, despite the strictures of the criminal law, many physicians have long been willing to provide such assistance.[16] They do so in response to an undeniable reality. More recent advances in medicine, which have dramatically increased the life span of the terminally ill, have also stretched out the "death span," prolonging the agony of the end stages of terminal disease,

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only by the living God." Quoted in P. Baelz, "Suicide: Some Theological Reflections," *in* Battin & Mayo, *supra*, at 75.

However deeply held such religious views may be, they cannot (without more) be the basis for government regulation. See *Casey*, 505 U.S. at 850 (explaining that particular spiritual or moral views concerning a liberty "cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code."); *id.* at 914 (Stevens, J., concurring in part and dissenting in part) ("[I]n order to be legitimate, the State's interest must be secular; consistent with the First Amendment the State may not promote a theological or sectarian interest.").

[15] *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261, 339 n.11 (1990) (Stevens, J., dissenting).

[16] See generally Julia Pugliese, Note, *Don't Ask—Don't Tell: The Secret Practice of Physician-Assisted Suicide*, 44 Hastings L.J. 1290, 1297-99 (1993); Timothy E. Quill, *Death and Dignity: A Case of Individualized Decision Making*, 324 New Eng. J. Med. 691, 694 (1991).

often accompanied by severe pain, physical deterioration, and unspeakable indignities.

In sum, a review of this nation's history and tradition in fact provides considerable support for recognition of a constitutionally protected liberty interest in the choice of the terminally ill to bring an end to their suffering by hastening an inevitable death.

B. The Right of a Mentally Competent, Terminally Ill Person to Choose an End to Suffering by Hastening an Inevitable Death Is Implicit in the Concept of Ordered Liberty.

The right of the terminally ill to hasten their death and escape intolerable pain is not only grounded in history, it is also implicit in the very concept of ordered liberty, as this Court has understood and applied that notion in past decisions. In particular, the combined force of *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 505 U.S. 833 (1992), and *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990), leads to the conclusion that the right of the terminally ill to quit a life burdened by intractable pain in a gentle and dignified manner is at the core of the liberty interests protected by the Constitution.

Cruzan and *Casey* do not stand alone, however. They represent only the latest examples of an enduring principle that has found expression in numerous cases over the years. This Court has repeatedly protected from state intrusion a set of decisions that go to the very essence of what it means to be an individual in command of a personal history and life course — decisions relating to marriage, family relationships, conception, procreation, child rearing, education, and the refusal or termination of life-saving medical treatment. See *Casey*, 505 U.S. at 849 ("It is settled now...that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood, as well as bodily integrity.") (citations omitted). Review of this well-settled line of cases reveals the vital presence of three distinct, though interrelated, components of "liberty," each of which strongly supports a finding of constitutional protection for the right of the terminally ill to hasten inevitable death.

The first and perhaps pre-eminent component of "liberty" protects the individual's interest in personal dignity and decisional autonomy. See *Moore* v. *City of East Cleveland*, 431 U.S. 494 (1977); *Roe* v *Wade*, 410 U.S. 113 (1973); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972); *Loving* v. *Virginia*, 388 U.S. 1 (1967); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Prince* v. *Massachusetts*, 321 U.S. 158 (1944). These cases develop the central notion that liberty only has meaning if an individual is able to make central decisions concerning his or her own life free from significant governmental interference. The decision in *Casey* stands as the most recent and most cogent articulation of these principles:

> These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

505 U.S. at 851.

It is beyond dispute that the decision to control the end of one's life when confronted with terminal illness and intolerable pain is among the most critical and personal decisions an individual can make. Indeed, given its profound significance to a person's individual, familial, moral, spiritual and religious beliefs, it is difficult to view any other life choice as striking more to the core of personal dignity and autonomy than the decision of a competent and suffering terminally ill patient concerning how and when to die. Both the majority and dissents in *Cruzan* stressed the fundamental nature of the choice at issue here. See *Cruzan*, 497 U.S. at 281 ("The choice between life and death is a deeply personal decision of obvious and overwhelming finality."); *id.* at 310-11 (Brennan, J., dissenting) ("Dying is personal. And it is profound. For many, the thought of an ignoble end, steeped in decay, is abhorrent. A quiet, proud death, bodily integrity intact, is a matter of extreme consequence."); *id.* at 343 (Stevens, J., dissenting) ("Choices about death touch the core of liberty. Our duty, and the concomitant

freedom, to come to terms with the conditions of our own mortality are undoubtedly 'so rooted in the traditions and conscience of our people as to be ranked as fundamental.'... [N]ot much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience.") (citations omitted).

The second component of "liberty" to be found in this Court's cases involves bodily integrity. The line of cases supporting this component arose primarily in the context of medical procedures, and a person's right to direct the course of his or her own treatment. See *Washington* v. *Harper*, 494 U.S. 210 (1990); *Winston* v. *Lee*, 470 U.S. 753 (1985); *Schmerber* v. *California*, 384 U.S. 757 (1966); *Rochin* v. *California*, 342 U.S. 165 (1952); *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). Here the *Cruzan* decision makes the latest and most germane statement about the role of bodily integrity in liberty. The majority in *Cruzan* explained that this Court's precedents indicate that "a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment," 497 U.S. at 278, and Justice O'Connor in concurrence stressed that "our notions of liberty are inextricably entwined with our idea of physical freedom and self-determination ...." 497 U.S. at 287 (O'Connor, J., concurring).

Cruzan stands for the proposition that the bodily integrity component of liberty, which encompasses the right to direct one's own medical treatment, is so fundamental that it is to be honored even when the consequence of the choice is hastening an individual's death. Accordingly, this component of liberty must extend to persons like the patient-plaintiffs who, with their lives ending and their bodies wracked with pain, sought the means to preserve their dignity and control over their bodily integrity by obtaining prescribed medication to terminate their suffering.[17]

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[17] Though the United States finds that "*Cruzan* supports the conclusion that a liberty interest is at stake in this case," Govt. Br. in *Glucksberg* at 15, it also suggests that this case does not involve *Cruzan*'s interest in "avoiding invasions of bodily integrity." *Id.* at 16. Such a view misses the reality of those who seek to exercise the right at issue here. Like the patient-plaintiffs in these cases, dying patients seeking to hasten death are typically in excruciating pain and often

The third and final component of "liberty" supporting the constitutional right of terminally ill patients to choose a peaceful death is the right to avoid intolerable suffering. As the United States highlights, see Govt. Br. in *Glucksberg* at 14, a liberty interest is surely implicated if the State itself inflicts severe pain and suffering. See *Ingraham* v. *Wright*, 430 U.S. 651, 674 (1977); see also *Hudson* v. *McMillian*, 503 U.S. 1, 9-10 (1992). A liberty interest is also implicated when the state interferes with an individual's ability to relieve his or her pain, as the United States again appropriately recognizes. See Govt. Br. in *Glucksberg* at 14-15; cf. *Estelle* v. *Gamble*, 429 U.S. 97, 104 (1976). *Casey* acknowledges that the ability to seek relief from pain is a component of the "liberty" protected under the Due Process Clause — especially when the pain at issue is itself integrally bound up with a decision which implicates the dignity and autonomy interests in directing one's own life course that are also the province of the Due Process Clause:

> The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear.... Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role.... The destiny of the woman must be shaped to a large

physically incapacitated; frequently their entire bodily existence is conscripted by the demands and relentless assaults of an incurable disease. To suggest that such persons' "bodily integrity" is unaffected if they are denied the opportunity to seek medication to bring their suffering to an end — and are thereby forced to continue an existence which they view as a torment — evinces a remarkably hollow conception of the right to bodily integrity. Of course, this Court's precedents encompass a much fuller conception of bodily integrity. As *Casey* made clear when it held that denial of access to the medical procedure of abortion touches "upon the very bodily integrity of the pregnant woman," 505 U.S. at 896, this Court has recognized an interference with a liberty interest whenever persons have particular courses of medical treatment thrust upon them or denied to them contrary to their interests or consent. See, *e.g.*, *Washington*, 494 U.S. at 229; *Jacobson*, 197 U.S. at 24-30; see also *Vitek* v. *Jones*, 445 U.S. 480, 494 (1980); *Parham* v. *J.R.*, 442 U.S. 584, 600 (1979).

> extent on her own conception of her spiritual imperatives and her place in society.

505 U.S. at 852.

The same principle applies where a state prohibition relegates competent, terminally ill individuals to continue to suffer acute pain without the option of a gentle, hastened death. Like the pregnant woman's decision, the decision of a terminally ill individual to quit life in the face of unendurable pain and certain death is too intimate, too personal, and too central to the totality and meaning of that person's life for the State to impose its own philosophical and moral imperatives upon that decision. Indeed, the personal stories of the patient-plaintiffs plainly illustrate the extent of the suffering at stake in these cases.[18] The United States properly recognizes this "significant liberty interest" in its brief, noting that "it persists even at the point at which avoiding severe pain and suffering coalesces with ending life." Govt. Br. in *Glucksberg* at 16. This view resonates fully with the decision in *Cruzan*, which

[18] Washington notes that respondents and their supporting amici placed before the Courts of Appeals numerous "anecdotes" of the terminally ill who wished to hasten their death and avoid painful, undignified and inhumane endings to their lives. The State of Washington urges that this Court not make constitutional decisions based on "anecdotes." See Washington Br. at 18. But these personal stories, though brief and obviously inadequate to portray essentially indescribable human suffering, are meant to help the Court to conjure the unimaginable pain and suffering experienced by those who might avail themselves of the right urged here. As the United States acknowledges, see Govt. Br. in *Glucksberg* at 18 & n.1, an irreducible core of terminally ill patients (including an estimated 10% of all cancer patients) cannot obtain relief through palliative treatment but are trapped in physical agony. In some cases, pain cannot be controlled even with full and appropriately timed doses of narcotics; in other cases, the toxic effects of the palliative agents may be intolerable. See Howard Brody, *Assisted Death — A Compassionate Response to Medical Failure*, 327 New Eng. J. Med. 1385 (1992). Moreover, the invocation of the capabilities of modern palliative medicine ignores the subjective nature of suffering; the diminished fortitude in the face of suffering when all hope of recovery is gone; the practical reality that pain can often only be allayed, if at all, at the cost of mental alertness; and the loss of dignity that accompanies physical deterioration. In these circumstances (the "anecdotes" that respondents and their amici place before the Court), compassion and the Constitution dictate that these terminally ill patients not be denied their wish for a hastened and gentle death.

teaches that a liberty interest persists even to the point where an individual decides to hasten his or her death through the refusal of life-sustaining treatment.[19]

These three components of "liberty," all recognized by this Court as hallmarks of "the concept of ordered liberty," forge a strong base of constitutional support protecting the right of a competent, terminally ill person to choose to end suffering by gently hastening death. To deny constitutional protection for this right would undermine concepts of liberty and autonomy previously recognized as sacrosanct. "Making someone die in a way that others approve, but he believes a horrifying contradiction of his life, is a devastating, odious form of tyranny."[20] The right to define the limits of one's endurance in the face of terminal illness and to embrace a swifter, more gentle death, should be recognized as an essential component of liberty under the Due Process Clause.

II.

A BLANKET PROHIBITION AGAINST AID TO SUICIDE UNDULY BURDENS THE RIGHT OF THE TERMINALLY ILL TO MAKE RATIONAL END OF LIFE DECISIONS

If this Court determines that the right of the terminally ill to escape intolerable pain and suffering through hastening death is a liberty interest protected by the Fourteenth Amendment, there can be little doubt that the laws at issue here "operate as a substantial obstacle" to the exercise of that constitutionally protected personal liberty interest. *Casey*, 505 U.S. at 893.

Amici acknowledge that the states have a significant interest in the preservation of life that permits them to regulate, even quite extensively, the exercise of the right of the terminally ill to choose

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[19] In *Cruzan*, this Court noted that the "logic of [prior] cases" would extend the liberty interest in refusing medical treatment to refusing "the forced administration of life-sustaining medical treatment, and even of artificially delivered food and water essential to life." 497 U.S. at 279.

[20] Ronald Dworkin, *Life's Dominion: An Argument About Abortion, Euthanasia, and Individual Freedom* 217 (1993).

the time and manner of their death. Indeed, such regulation is undoubtedly appropriate to ensure that the right at issue here is not misused. This case, however, does not involve regulation, but prohibition. And, in this context, it is undeniable that an *absolute* ban on obtaining assistance from a physician unduly burdens the right of the terminally ill to escape pain by hastening death. Indeed, for many terminally ill patients, it precludes it entirely. Furthermore, there are less restrictive alternatives available that would in fact better serve the interests claimed by the states in this case.[21]

A. A Blanket Ban on Assistance to Suicide Is a Substantial Obstacle to the Right of the Terminally Ill to End Their Suffering.

A state's blanket prohibition against aid in dying unduly burdens the right of terminally ill individuals to end their suffering and hasten their death, preventing significant numbers of terminally ill from achieving the release from suffering that they desire and relegating still others to unacceptable options. Along with improving and extending life, the advances of modern medicine have transformed radically the social circumstances of death. Whereas only a generation ago the vast majority of persons died at home, now approximately 80% of individuals die in hospitals and long-term care institutions.[22] It is, as a practical matter, impossible for

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[21] This Court has not always employed a single test when weighing the strength of the state's asserted justification for abridging a fundamental liberty interest. In *Casey*, the Court adopted an "undue burden" test that focussed on whether the challenged regulation placed a "substantial obstacle" in the path of a woman seeking a pre-viability abortion. In other contexts, this Court has emphasized the need for narrow tailoring. See, *e.g.*, *City of East Cleveland*, 431 U.S. at 499. Under either formulation, a total ban on physician-assisted suicide cannot be upheld. As explained below, it clearly represents a "substantial obstacle" to terminally ill individuals who wish to end their suffering and it is not narrowly tailored to achieve the state's asserted interests.

[22] See *Cruzan*, 497 U.S. at 302 (Brennan, J., dissenting); *id.* at 339-40 (Stevens, J., dissenting) ("People are less likely to die at home, and more likely to die in relatively public places, such as hospitals or nursing homes. Ultimate questions that might once have been dealt with in intimacy by a family and its physician have now become the concern of institutions.").

the terminally ill who are institutionalized to obtain release from suffering unassisted; without aid, they are unable to obtain the means for a swifter death. Moreover, a state's blanket prohibition against aid in dying presents an absolute obstacle to those who do not wish to quit their lives until their terminal illnesses progress to the point at which they lack the very strength to accomplish suicide unassisted. One consequence is particularly intolerable. Faced with increasing weakness and loss of autonomy in the final stages of an illness, terminally ill patients who have chosen to avoid lengthy and excruciating deaths are frequently forced to end their lives prematurely for fear that further loss of strength or intense medical supervision effectively will deprive them of their choice.

Furthermore, such terminally ill patients often are driven to end their lives by violent means and entirely alone. Ironically, such violent means are often legally accessible, whereas the medical means that might allow the patient to quit life gently are now inaccessible in the absence of a physician willing to transgress the law. The fear of implicating one's friends or family in crime, moreover, often induces the terminally ill to carry out their resolve secretly and alone. The trauma is then magnified for friends and family who must deal not only with the death, but the gruesome means employed and the fact that their loved one was forced to meet death unsupported and alone.[23]

Other terminally ill individuals determined to end their suffering frequently turn for help to friends or family members, who must then choose between love and compassion or the dictates of the law.[24] Another cruelty caused by the ban on assistance is that

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[23] The ban on physician assistance may not only cause terminally ill individuals to commit suicide prematurely or preclude a gentle death or one in the company of friends and family, but it also may frustrate the very desire for certain death when self-inflicted attempts fail, thereby causing additional and gratuitous suffering to the tormented patient. See Quill, *supra* note 16, at 117-20.

[24] See, *e.g.*, K. Frederickson, *Torn Mother: I Helped Her Pass On*, Oregon Bulletin, May 16, 1994, at A1 (giving account of mother's explanation, after expiration of statute of limitations, of how she finally acceded to daughter's plea to assist her suicide after months of watching her wasting from bone cancer in too much pain to endure even her mother's touch).

non-physician assisted suicides are amateurish affairs, always clandestine and often bungled. One Canadian study of "back-alley euthanasia" among the Vancouver AIDS population found that one-half of assisted suicides were botched, perversely increasing — rather than alleviating — suffering.[25]

B. The States' Asserted Interests Do Not Justify an Absolute Ban on Physician Aid in Dying for the Terminally Ill.

In opposition to this right, Washington and New York invoke interests in preserving human life, precluding undue influence or mistake, safeguarding the integrity of the medical profession and a concern over the "slippery-slope" — *i.e.*, that line-drawing in this area will prove impossible. These interests and concerns, however legitimate, do not justify an absolute ban on physician aid in dying for terminally ill persons and should not outweigh the recognized right of a competent, terminally ill individual to end his or her suffering.

1. Interest in Preserving Each Citizen's Life

First, as this Court has determined, a state's interest in the preservation of every citizen's life, such as that asserted by New York and Washington here, abstracted from the value that a particular person may place on the continuation of that life, cannot outweigh a terminally ill individual's choice to end suffering and quit a life burdened by intractable pain and irreversible disintegration. See *Casey*, 505 U.S. at 857 ("[A] State's interest in the

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[25] See Clyde H. Farnsworth, *Vancouver AIDS Suicides Botched*, N.Y. Times, June 14, 1994, at C12. For example,

> In five cases, victims were unsuccessfully suffocated. In one case, the people who assisted in the suicide resorted to slitting the victim's wrists with a razor blade and in another case to shooting him. Two were injected with pure heroin. Many of the acts of euthanasia took several hours or longer to be completed. In one case it took four days.

Id.; see also Gina Kolata, *AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure*, N.Y. Times, June 14, 1994, at C1 (reporting on man who, in trying to bring on a gentle death by smothering his lover with pillow, asphyxiated him only enough to destroy most of his brain function).

protection of life falls short of justifying any plenary override of individual liberty claims.").[26]

Second, the pitiless process by which many terminally ill persons die — the unremitting pain, the erosion of privacy and dignity, the loss of control over basic bodily functions — leads some to conclude that the burden of their corporeal existence degrades the very humanity it was meant to serve. In choosing to end their suffering, the terminally ill do not repudiate an interest in life but seek to affirm a meaningful life with a dignified death.[27]

In these circumstances, a state may not insist that the terminally ill endure the unendurable in order to promote the state's abstract interest in the preservation of life. To do so is to appropriate an individual's existence, and to prolong cruel and unusual torment, for the purpose of proselytizing the state's preferred philosophical view of life. This a state may not constitutionally do.[28]

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[26] In *Cruzan*, the majority stated :

> we think a State may properly decline to make judgments about the "quality" of life that a particular individual may enjoy, and simply assert an unqualified interest in the preservation of human life to be weighed against the constitutionally protected interests of the individual.

497 U.S. at 282. Indeed, a state has no other choice. More specifically, a state cannot make determinations about the worth or quality of an individual's life and then rely on that determination as a basis for making life or death decisions. For the terminally ill, the meaning of life and the impact of physical and psychological agony represent the most personal of judgments that the state may not usurp.

[27] As Justice Stevens noted, an interest in life "includes an interest in how [one] will be thought of after ... death by those whose opinions mattered" during life. "How [one] dies will affect how that life is remembered." *Cruzan*, 497 U.S. at 344 (Stevens, J., dissenting). Those enduring a life racked with pain and utter helplessness may reasonably reject the prospect of a long vigil where family and friends loyally and lovingly witness their disintegration. The terminally ill reasonably may assert an interest in being remembered for how they lived rather than the excruciating, relentless and lengthy process by which they died.

[28] A state may not even use a person's car as a moving billboard to proselytize its views on life's meaning by insisting that the state's motto appear on citizens' license plates. See *Wooley* v. *Maynard*, 430 U.S. 705 (1977). In the abortion context, a state may not insist that a woman carry a not-yet-viable life to term to affirm the state's view of women's role or its philosophic view of when life

2. Preventing Undue Influence or Mistake

Washington and New York also rely on their interest in protecting vulnerable citizens. They argue that the right at issue, if recognized, would be subject to abuse and mistake — that requests for aid in dying would be mistakenly granted to those not terminally ill (because incorrectly diagnosed) or to those whose request was not truly voluntary (due to undiagnosed depression, lack of capacity, inadequately treated pain, or undue influence from family or physician).

These concerns, however, are not unique to the present situation. The risk of abuse or mistake exists in many medical contexts, including the end-of-life decisions already condoned by the State. These risks are routinely and appropriately dealt with through regulation. For example, only an informed competent adult may consent to an order not to resuscitate. See, *e.g.*, N.Y. Pub. Health Law §§ 2960 *et seq.* (McKinney 1993). Similarly, only a competent principal may appoint a health care agent (who may be a family member) who has the power to decide not to resuscitate or to terminate life support for the principal in the event of incapacity. See, *e.g.*, N.Y. Pub. Health Law § 2981 (McKinney 1993). Indeed, under applicable state statutes, a finding of competence is a necessary precondition to the execution of health care directives.[29]

If the law permits life-ending actions to be taken on the basis of competence in other medical contexts, there is no reason to claim that such a determination is impossible in this setting. Moreover, the recognition of the right to physician aid-in-dying would better address some of the state's concerns here. Whereas the current legal regime may lead the terminally ill to hide their wish for suicide from their doctor for fear that needed pain medication may be withheld, recognition of the right to physician assistance in hastening death would encourage frank discussion between the terminally ill considering suicide and their treating

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begins. See *Casey*, 505 U.S. at 851. Equally, a state may not promote its view of the sanctity of life by insisting that a terminally ill individual bear unrelieved suffering rather than hasten death.

[29] See generally *Compassion*, 79 F.3d at 818 (citing numerous statutes).

physician. Such discussions necessarily would raise the issue of the patient's mental state and the pain being experienced, and lead to the provision of treatment for depression, where warranted, or for pain, where all available methods have not been tried. Furthermore, where family or friends have improperly planted the thought of suicide, involvement of an objective physician would be salutary.

With respect to the concern over mistaken diagnosis (as with the previous concerns), safeguards short of an absolute ban can be crafted to minimize the likelihood of misdiagnosis to a very small order of probability.[30] Furthermore, the risk is equally present in other end-of-life decisions already condoned by the state such as the withdrawal or refusal of life-support by the terminally ill.[31]

Furthermore, the state's concerns regarding mistake in the exercise of the right ignore the consequences of a prophylactic outright ban on the terminally ill who are unquestionably competent and unquestionably in the end-stage of terminal disease. These terminally ill would be left acutely to suffer — having been foreclosed, as the United States acknowledges, from the "one

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[30] Model regulations have provided that a patient seeking physician assistance in hastening death receive confirmation by at least two physicians (or an entire committee of physicians) that they are in the terminal phase of their illness before such a request will be honored. See *infra* p. 22 & n.34.

[31] The United States argues that an incorrect diagnosis in the case of the withdrawal of life support does not, as it would here, result in death. See Govt. Br. in *Quill* at 14. In support, the United States points to Karen Ann Quinlan, who lived for years after her life support was disconnected. *Id.* But the Government's argument conflates two possibilities of misdiagnosis at stake in a terminally ill patient's decision to withdraw life-support and hasten death: dependence on life-support (not at issue in this case) and the terminal phase of an irreversible disease (which is at issue in this case). Withdrawing life-support does not lead to death where there has been a misdiagnosis of dependence on life support. On the other hand, where the misdiagnosis involves the reversibility of the disease (*i.e.*, whether it is terminal) — the only diagnosis at issue here — a misdiagnosis leading to withdrawal of life support will lead to a death. In such cases, a person whose condition might have improved if retained on life support, is removed from life support and allowed to die. Despite such risks (which can be and are minimized through requirements of diagnostic confirmation), the right to hasten death through directing the discontinuation of life support has been vouchsafed to the terminally ill.

humane and certain route of escape from pain and suffering." Govt. Br. in *Quill* at 15. These individuals, whose lives have already been so horribly compromised, cannot be forced to such a sacrifice.

Moreover, the current *unregulated* practice of assisted suicide by the terminally ill is clearly more subject to the abuse and mistake that concern petitioners and their amici. Existing back-alley methods provide no safeguards at all and thus no assurance that diagnosis will be accurate, that depression will be identified, and that undue influence has not been exercised. Yet, if the right claimed here is not recognized, certain terminally ill patients who are incapable of enduring further suffering will resort to self-help or the back-alley methods currently available with all of their significant risks.

Accordingly, amici urge recognition of the right claimed by respondents. Amici also support the use of legislative safeguards to ensure that all requests of the terminally ill for aid in dying are the product of thoughtful and informed self-determination.[32] Petitioners have offered no persuasive justification to support the need for a total prohibition.[33]

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[32] The recommendation of the New York State Task Force, relied on heavily by petitioners and their amici, is instructive in this context. In its 1994 report, *When Death Is Sought; Assisted Suicide and Euthanasia in the Medical Context*, the New York State Task Force on Life and the Law unanimously recommended that New York's statutory ban on assisting suicide be retained due to the risk of abuse and mistake if physician-assisted suicide for the terminally ill was allowed. In support of its recommendation, the New York State Task Force, like New York and Washington herein, focused on requests that were or might be made due to untreated pain or depression or undue influence. But when confronted with the specific issue raised by these cases — voluntary requests from the competent and suffering terminally ill — some Task Force members endorsed assisted suicide as a means of showing respect for the autonomy, and compassion for the suffering, of these patients. They preferred, however, that such patients obtain medical help clandestinely from courageous doctors willing to violate the law. See *id.* at 141. Thus, in the circumstances directly and solely at issue here, some members of the Task Force urged that the New York laws be disobeyed.

[33] The briefs of petitioners and their supporting amici rely on anecdotes (and selective studies — which are not uncontradicted — about experiences in another nation) to argue that regulation could not effectively safeguard the right claimed here. Notably, these anecdotes do not involve the exercise of the right to the

Indeed, several model statutes for physician assistance to the terminally ill already exist that incorporate procedural safeguards to screen out inappropriate cases, including requirements of: witnesses to ensure voluntariness (neither related to the patient nor involved in his or her treatment); reasonable waiting periods to preclude rash decisions; confirmation by a second physician of the terminal diagnosis and that the patient has been receiving proper palliative care; psychological examination to ensure that the patient is not suffering from a momentary or treatable depression; and reporting procedures.[34]

3. Implicating Doctors in Killing and Slippery-Slope Arguments

Petitioners and their amici also contend that affirming the decisions below will lead to the erosion of society's confidence in the medical profession by implicating physicians in intentional killings. But, as the Second Circuit correctly noted, the physician assistance sought by patient-plaintiffs in this case, "the writing of a prescription to hasten death ..., involves a far less active role for the physician than is required in bringing about death through" the withdrawal of life support. *Quill* v. *Vacco*, 80 F.3d 716, 729 (2d Cir. 1996). Accordingly, the right the patient-plaintiffs wished to exercise in this case implicates doctors in intentionally killing, and risks tarnishing their image, no more than does the currently

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refusal or withdrawal of life-sustaining treatment which *has* been effectively regulated. Instead, petitioners and their amici rely largely on hypothesized scenarios and anecdotes relating to the clandestine exercise of physician aid in dying, which at present is illegal and entirely unregulated. Neither these, nor the disputed experience of another nation, provide a sufficient basis to argue against the right urged here.

[34] See Oregon's Death with Dignity Act, Or. Rev. Stat. §§ 127.800-127.995 (1995); Michigan's Model Statue Supporting Aid-in Dying, appended to the Final Report of the Michigan Commission on Death and Dying (1994); New York, Senate Bill No. 7986 (May 3, 1994) entitled "Death With Dignity," sponsored by New York State Senators Galiber, Leichter, Markowitz, Smith and Waldon; Washington Senate Bill 5596 (Jan. 27, 1995) entitled "Terminally Ill Patient Act of 1995." Of course, the constitutionality of particular restrictions is not before the Court since the two state statutes in this case are both total bans.

sanctioned practice of removing life-sustaining medical treatment. See *Compassion*, 79 F.3d at 828 ("Given the similarity between what doctors are now permitted to do and what the plaintiffs assert they should be permitted to do, we see no risk at all to the integrity of the profession."). Furthermore, since safeguarding of the right at issue here will permit and encourage candid discussions of all available options between the terminally ill and their physicians, instead of "criminaliz[ing] the provision of medical assistance to patients in need," *id.* at 827, recognizing the right of the terminally ill to obtain the relief they seek from their doctors would foster rather than erode public confidence in the medical profession.

The other argument raised by petitioners and their supporting amici is that recognition of the right to physician aid in dying urged here would somehow be uncontainable. These sorts of slippery-slope arguments can be made in opposition to any constitutional right (and have been leveled against many recently recognized rights, including the right to terminate life-sustaining treatment). Recognition of any right creates the possibility of its abuse; but petitioners do not raise any cogent concerns that could not be addressed in ways that still allow the right to be exercised.

Finally, Petitioners point to the difficulty in defining the category of the "terminally ill." In fact, this term has been used (and defined) in "living will" statutes in effect in 40 states. See *Compassion*, 79 F.3d at 818 & nn.77-78 (listing state statutes). While the term is not free from difficulty, it has proved workable and is not problematically vague.[35]

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[35] Petitioners point further to the difficulty in distinguishing between a physician's prescription of lethal medication to be self-administered by a terminally ill patient and a physician's administration of that medication where the terminally ill individual is unable to do so. Amici acknowledge that some terminally ill patients who voluntarily request a hastened and gentle death may, due to the devastating progress of their disease, be unable physically to ingest medication without assistance. The question whether the physician's administration of the medication could be constitutionally prohibited in such a case is not presently before the Court. Amici, however, agree with the Ninth Circuit that the crucial question is whether the request is thoughtful and voluntary and, if so, the terminally ill patient who is physically unable to administer the medication that would release him from his agonies cannot, consistent with the Constitution, be

III.

BECAUSE TERMINALLY ILL PATIENTS ON LIFE SUPPORT HAVE THE RIGHT TO MEDICAL ASSISTANCE IN HASTENING DEATH, DENYING TERMINALLY ILL PATIENTS NOT ON LIFE SUPPORT MEDICAL ASSISTANCE IN HASTENING DEATH VIOLATES THE EQUAL PROTECTION CLAUSE OF THE FOURTEENTH AMENDMENT

The arguments supporting the right urged here are further buttressed by the fact that New York, Washington and most other states have recognized the right of a competent, terminally ill patient to choose to end a dehumanizing process of dying by hastening inevitable death. Indeed, they have recognized the right to physician assistance in implementing this choice. Most states, however, have explicitly extended this right only to a limited category of terminally ill patients: those dependent on life-support, including life-sustaining hydration and nutrition, who are permitted to end their suffering by directing the termination of such treatment even where the express purpose of such action is to hasten death. Physicians who comply with these directives are immune from criminal liability. But other terminally ill patients, also facing imminent death but not undergoing such treatments, are not granted the right to truncate a dehumanizing and agonizing dying process and to embrace a swifter death through medical assistance.

The Equal Protection Clause mandates that "all persons similarly circumstanced shall be treated alike." *Royster Guano Co.* v. *Virginia*, 252 U.S. 412, 415 (1920). The Second Circuit recognized that, with respect to the decision to end intolerable suffering by hastening an inevitable death, all terminally ill persons are

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prevented from obtaining the necessary aid. See *Compassion*, 79 F.3d at 831-32. The fact that the right urged here may one day properly be extended to include such a case is no cause for alarm. It bears no relation to the entirely speculative, nightmare scenarios pained by certain amici supporting petitioners: that the right urged here — a right of the individual against the state for release from the unendurable ravages of terminal disease — somehow will metamorphosize into the ability of society to act against the individual and do away with those whose lives are no longer valued. Such dark fantasies should be disregarded.

similarly situated, whether or not on life support. But, by denying only those not on life support access to a medical means to achieve their desired end, "New York law does not treat equally all competent persons who are in the final stages of fatal illness and wish to hasten their deaths." *Quill* v. *Vacco*, 80 F.3d 716, 727 (2d Cir. 1996). Accordingly, New York's laws (and their Washington equivalents) which prohibit only some terminally ill from obtaining an escape from their pain "are violative of the Equal Protection Clause." *Id.*

Petitioners argue that there is a constitutionally significant distinction between the withdrawal of medical treatment (even life-sustaining medical treatment) and the release from suffering sought by the respondents in this case. In fact, as the United States essentially acknowledges, see Govt. Br. in *Quill* at 10, 13, and as the Second Circuit found, see *Quill*, 80 F.3d at 729-30, there is no material distinction between the patient's choice in either case or between the physician's involvement in accomplishing that choice.

In both cases the patient is making the decision to curtail weeks or months of suffering in the face of further devastation and certain death. Terminally ill patients who request the discontinuance of life-sustaining treatment, like the terminally ill patient-plaintiffs who by this action sought to hasten death by consuming drugs prescribed for this purpose, have made a conscious decision to die and seek medical assistance to accomplish their desire.[36] The medical assistance required to implement this choice is far greater (both in terms of quantity of activity and causal nexus to death) than the prescription of medication to be self-administered by the terminally ill. In the case of the withdrawal of life support, the physician must remove the medical machinery sustaining life, monitor the resultant accelerated dying process and administer morphine or barbiturates to ease the pain that would otherwise

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[36] See *Quill*, 80 F.3d at 729 (citing *Cruzan*, 497 U.S. at 296-97 (Scalia, J., concurring)).

attend such a death. These medications typically must be administered in doses that in fact precipitate an even earlier death.[37]

Thus the Talmudic distinction petitioners press between the allegedly "natural" death accomplished by withdrawing life-sustaining treatment and the allegedly "unnatural" deaths sought here, is not sustainable. In both cases the motive force is the patient's intention to hasten impending and certain death and in both cases the physician provides the medical assistance to ensure that the patient's desire can be accomplished in a certain, gentle and medically supervised manner. As the Second Circuit rightly concluded in *Quill*, the withdrawal of life-sustaining treatment by the physician is not "passive" assistance to that desire nor does it allow for a "natural" death. See 80 F.3d at 729.

Petitioners' specious distinction between, and undue emphasis upon, natural and unnatural deaths has warped treatment decisions made by compassionate doctors wishing to respond to requests from terminally ill patients who are not on respirators or receiving artificial nutrition and hydration but who, nonetheless, have reached the limit of their endurance. In such cases, physicians sometimes have aided these patients by contriving a death that mimics those regarded by petitioners as "natural." This practice, sometimes referred to as terminal sedation, involves medicating the patient into a sleep-like state until the patient dies of starvation or dehydration, days or perhaps weeks later. See AMA Br. in *Glucksberg* at 10; Resp. Br. in *Quill* at section III.B.

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[37] The Second Circuit's discussion of this point bears repeating:

> [T]he writing of a prescription to hasten death, after consultation with a patient, involves a far less active role for the physician than is required in bringing about death through asphyxiation, starvation and/or dehydration. Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide.

Quill, 80 F.3d at 729.

Indeed, as part of palliative care for the terminally ill, doctors routinely have supplied the causal agent of patients' deaths under the doctrine of "double effect." Where the terminally ill suffer from intractable pain in the final stages of disease, doctors sometimes will choose to administer an intravenous morphine drip that eases suffering by inducing a sleep-like state and also hastens death by suppressing respiration; as with terminal sedation, death may be precipitated in a matter of days. Medical ethicists and the Catholic Church justify action such as terminal sedation and morphine drips on the ground of the "double effect," reasoning that the physician's operative intent is to relieve pain, while death is regarded as a foreseen but unintended consequence.

But the patients at issue in these cases also seek a release from suffering, and also believe that such relief can only be accomplished by their deaths. There is no constitutionally cognizable reason that the prescription of medication to eliminate suffering and achieve a peaceful death can only be legally permissible where death is accomplished gradually (by starvation, dehydration or asphyxiation) while the patient is put into a twilight zone that can last days or weeks. This option, where one is subject to the unknown sensory experiences and state of consciousness that might attend such a drug induced coma, while one's loved ones stand vigil for days or weeks, may appear a monstrous and horrifying prospect to the terminally ill who wish for a certain and gentle death.

Moreover, the practice of terminal sedation and intravenous morphine drip places the decision in the hands of doctors rather than patients.[38] Amici urge that the right pressed here — which is

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[38] Where a patient requests aid in dying quickly, the patient endangers the delicate excuse of the "double effect" and a doctor who otherwise might have employed a morphine drip may demur, afraid of running afoul of the criminal law. See Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. Times, Nov. 1, 1994, at A27.

also meant to relieve suffering by hastening inevitable death — better serves the needs and autonomy interests of terminally ill patients.

The distinction urged by petitioners between the competent terminally ill who wish to die and those who wish to terminate life-sustaining treatment (or who are willing to undergo terminal sedation) certainly cannot survive the heightened scrutiny required when fundamental rights are at stake and, as the Second Circuit found, its very rationality is difficult to ascertain.[39] In short, because a complete ban on the prescription of medication to competent terminally ill patients who wish to hasten death does not serve the state's expressed interest as well as would appropriately drawn regulations, it is violative of the Equal Protection Clause.

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[39] Interestingly, the United States suggests that this Court need not be especially vigilant in reviewing the state's line drawing here because "[t]erminal illness does not single out any discrete or insular minority; it potentially affects all Americans." Govt. Br. in *Glucksberg* at 31-32. On this basis, the United States asserts that "there is every reason to believe that the state legislatures will address the competing interests in an impartial and unbiased way," and also contends that "there is no indication that the political processes are malfunctioning." *Id.* at 31 & n.3. This argument fails, of course, if a fundamental liberty interest is at stake because, in that circumstance, heightened scrutiny is required regardless of whether a discrete and insular majority is involved.

Furthermore, as a matter of practice, it is difficult to put faith in the political processes which have traditionally not acted to safeguard the right of the terminally ill to escape pain through a gentle, hastened death while prosecutors, courts and juries have never meaningfully punished anyone for helping the terminally ill exercise this right. See *supra* p. 7 & nn.12-13. This disjunction between the law on the books and the law in enforcement bespeaks a malfunctioning of the political process.

CONCLUSION

For the foregoing reasons, Amici respectfully request that the judgments of the Courts of Appeals be affirmed and that the New York and Washington statutes prohibiting physician-assisted suicide be declared unconstitutional as applied to mentally competent, terminally ill perso ıs requesting such aid to escape unendurable suffering.

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APPENDIX

Appendix

INTERESTS OF AMICI CURIAE

The American Civil Liberties Union ("ACLU") is a nationwide, nonprofit, nonpartisan organization with nearly 300,000 members dedicated to preserving the principles of liberty and equality embodied in the Constitution. Since its founding in 1920, the ACLU has participated in numerous cases before this Court. Of particular note here, the ACLU appeared as counsel in both *Planned Parenthood of Southeastern Pennsylvania* v. *Casey*, 112 S. Ct. 2790 (1992), and *Cruzan* v. *Director, Missouri Dept. of Health*, 497 U.S. 261 (1990). The ACLU of Washington is a state affiliate of the ACLU and appeared as amicus curiae before the Ninth Circuit in *Compassion In Dying* v. *Washington*.

The National Gray Panthers Project Fund is a civil liberties advocacy project concerned with social justice for the aging. As advocates for the aging, the Gray Panthers and their state affiliates of Washington and New York join in this case, as a friend of the court, to highlight the right of individuals to make choices about the quality of their lives.

The Japanese American Citizens League ("JACL") is a national civil rights organization founded in 1930, committed to strive to secure justice and equal opportunities for all Americans of Japanese ancestry as well as for all Americans, regardless of race, creed, color, national origin, religion, sex, sexual orientation, or disability. The JACL supports legislative initiatives that provide for the welfare of the broader community. The Pacific Northwest District of JACL also joins in this amicus brief as a advocate for the health care needs, as well as the death with dignity needs of its membership and of the total community, upholding the individual's right to freedom of choice on those matters that are essential to basic human dignity.

The Humanists of Washington is a freethought association dedicated to the principles of secular humanism. The group supports intellectual freedom, free inquiry, critical thinking, and civil liberties. Humanists of Washington's defense of civil liberties is unconditional; it works for the right of individuals to make personal decisions about their bodies free from unnecessary

government intrusion. Accordingly, the group defends, among other things, the right of terminally ill persons to choose the time and manner of their death.

The **Hemlock Society USA** was formed in 1980 to achieve the legalization of physician aid in dying for terminally ill, mentally competent adults. It has 25,000 members in 80 chapters and community groups throughout the country. The New York State and Washington State affiliates join the national organization in supporting the right of dying persons to work with their physicians so that the voluntary request for a hastened death may be part of the continuum of care available to the terminally ill.

The **Euthanasia Research & Guidance Organization ("ERGO!")**, a non-profit educational corporation organized under the laws of the State of Oregon, was founded in 1993 to lay the groundwork for the compassionate and just implementation of a mentally competent terminally ill adult's decision to hasten death when the law permits it in America. ERGO promotes safeguards and guidelines on legal, medical, and ethical issues so that physician aid in dying will be put into careful practice. Its goal is to educate and prepare individuals and institutions, ensuring a smooth transition when the change in law occurs. ERGO supports the respondents' position that a mentally competent terminally ill adult has the right to hasten inevitable death with the assistance of a physician.

AIDS Action Council is the Washington, D.C. representative of over 1,000 community-based organizations and the people living with HIV/AIDS they serve across the nation. As the only national organization devoted entirely to federal advocacy on behalf of people living with HIV/AIDS, AIDS Action works to ensure that effective national initiatives for prevention, care, and research are developed and implemented which are responsive to and respectful of the needs of all people living with or at risk of HIV/AIDS. In that regard, AIDS Action supports policies that empower people living with AIDS to exercise their fundamental right to make individual decisions about how they live with this disease, including their right to choose in a dignified and humane way the manner and time of their death with the assistance of their physicians.

The Northwest AIDS Foundation is the largest private, non-profit HIV/AIDS service and education organization in Washington state. The Foundation is dedicated to ensuring and maintaining the highest quality of life for persons living with HIV/AIDS, preventing the spread of HIV and advocating for all those whose lives have been affected by HIV/AIDS. Knowing the pain their clients experience as their illness becomes terminal, incapacitating, and untreatable, the Foundation supports the right of all persons with a terminal illness to decide for themselves when to end their own lives and for those individuals to seek assistance in doing so if they so wish.

The Seattle AIDS Support Groups ("S.A.S.G.") mission is to provide emotional support in a group setting (via support groups and a drop-in center) to persons living with HIV/AIDS and to their families, friends, and loved ones. The group's commitment is to create a safe and supportive environment fostering dignity, fullness of life and personal empowerment for persons with AIDS. By fostering dignity and personal empowerment, S.A.S.G. seeks to validate each individual's own choices about living and dying with this disease. The group believes that the option to hasten inevitable death should be a right for all terminally ill persons who elect to make that choice.

Local 6 of the Service Employees International Union ("Local 6") is a labor union representing 10,000 workers in Washington. As almost every improvement in the condition of working people has been accomplished by the efforts of organized labor and as the welfare of workers in Washington can best be protected and advanced by united action, the mission of Local 6 is to gather and expend its resources and to unite and empower its members for the advancement of working people. As a organization, Local 6 believes that people should exercise control over their lives and take responsibility for their decisions.

The mission of **Temple De Hirsch Sinai ("Temple")** is to serve the spiritual needs of its congregation through the observation, celebration, and study of reformed Judaism. It affirms the principles of reformed Judaism through its religious services, life

cycle ceremonies, religion school, social action, and outreach to individuals and families. The Temple promotes Jewish ideals in personal conduct, dedication, family and community life, and in its partnership with other institutions. Its interest comes under the tenets of the Old Testament, where all Jews are admonished to assist and share with the provision of food, clothing, and shelter for those less fortunate. The Temple's specific interest in this case is equal treatment of all citizens of this country.

The Older Women's League ("OWL") is a national organization working to better the lives of all midlife and older women. One of its agenda items is "Staying in Control Through All of Life." OWL works to improve policies and legal means to protect each individual's decision-making capability affecting quality of life until its ending. The Seattle/King County Chapter of OWL joins as amicus to support the right of the terminally ill to decide to end their suffering.

AMICUS CURIAE

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October Term, 1996

State of Washington
v.
Glucksberg

Vacco
v.
Quill

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND AND NINTH CIRCUITS

Brief for the *Amici Curiae*: Gay Men's Health Crisis and Lambda Legal Defense and Education Fund: On Behalf of their Members with Terminal Illnesses; and Five Prominent Americans with Disabilities: Evan Davis, Hugh Gregory Gallagher, Barbara Swartz, Michael Stein and Susan Webb In Support of Respondents

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TABLE OF CONTENTS

I. INTERESTS OF AMICI CURIAE 1

A. The Disability Rights Movement 2

B. The Views of People with Disabilities 4

C. The Interests of People with Disabilities 6

II. SUMMARY OF ARGUMENT 7

III. ARGUMENT 9

A. PEOPLE WITH DISABILITIES ASSERT THAT PEOPLE WITH TERMINAL ILLNESSES HAVE A CONSTITUTIONAL RIGHT TO HASTEN INEVITABLE DEATH WITH THE ASSISTANCE OF THEIR PHYSICIANS 9

1. Competent, Terminally Ill Adults Have a Strong Liberty Interest Under the Fourteenth Amendment in Making End-of-Life Decisions Free of Undue Government Interference 10

2. The Second Circuit Implicitly Agreed With the Ninth Circuit That There is a Liberty Interest for People with Disabilities (and Other Individuals) With Terminal Illnesses in Hastening Their Own Death 11

3. The Liberty Interest Asserted Here Is Fundamental and May Not Be Impaired Without a Compelling State Interest 12

4. There is No Compelling State Interest in Denying Terminally Ill Individuals the Right to

Die, and the Liberty Interest of the Individual Substantially Outweighs Any State Interests . 13

5. The Legitimate State Interest in Protecting People with Terminal Illnesses or Other Disabilities from Abuses Can Be Protected Through State Regulation 14

B. THE RIGHT TO ASSISTANCE IN DYING WILL BENEFIT PEOPLE WITH TERMINAL ILLNESSES, AND WILL NOT ADVERSELY AFFECT OTHER PEOPLE WITH DISABILITIES 16

1. Neither the Strong Liberty Interest in Hastening Death, Nor the Diminished State Interest in Interfering With This Decision, Are Based on Any Externally-Imposed Quality-of-Life Considerations 16

2. The Right to Hasten Inevitable Death is a Benefit for People with Terminal illnesses That is Not Prohibited By Either the Equal Protection Clause or the Americans with Disabilities Act. 16

3. The Standard of Terminal Illness Will Allow States to Prevent People Who Are Not Terminally Ill from Ending Their Lives With Physician Assistance 19

4. The Standard of Voluntariness Will Allow States to Ensure Only Competent Individuals Who Choose to Hasten Death With Assistance Are Allowed to Do So 20

5. In the United States, the Right of Terminally Ill Individuals to Choose Assisted Suicide Will

Never Be Converted into a Right of the State to Authorize the Murder of People with Disabilities 21

C. DENIAL OF THE RIGHT TO ASSISTANCE IN DYING WOULD DENY PEOPLE WITH TERMINAL ILLNESSES THE EQUAL PROTECTION OF THE LAWS 24

D. A COMPASSIONATE SOCIETY THAT RESPECTS PEOPLE WITH DISABILITIES MUST NOT DENY TERMINALLY ILL INDIVIDUALS THE RIGHT TO END THEIR SUFFERING WITH ASSISTANCE 24

1. The Decision of a Competent, Terminally Ill Individual to End His or Her Life Must Be Assumed to Be Rational and Should Be Respected 25

2. Recognition of the Right to Receive Physician Assistance Will Serve to Ensure Safety and Curtail Abuse 26

3. People with Terminal Illnesses Should Not Be Compelled to Die in a Drug-Induced Semi-Conscious Haze 28

4. Physician Assisted Suicide Allows People with Terminal Illnesses to Postpone Ending Their Lives Until a Later Phase of Their Illness ... 29

IV. CONCLUSIONS 29

APPENDIX

TABLE OF AUTHORITIES

Cases

City of Cleburne, Tex. v. Cleburne Living Center, 473 U.S. 432 (1985) 17

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I. INTERESTS OF AMICI CURIAE[1]

People with disabilities do not speak with one voice on whether individuals with terminal illnesses should be permitted to end their own suffering with the assistance of their physicians and to choose a death with dignity. While some members of the disability community have been extremely vocal in opposing the right to assisted suicide, the majority of individuals with disabilities, including the *Amici* filing this brief, believe that such a right exists – that it is entirely consistent with our Constitutional tradition and the hard-fought rights secured by the disability rights movement in this country.

Amici are individuals and organizations representing people with a broad array of disabilities who share the common belief that individuals with disabilities should have autonomy over the decisions that affect their lives. They believe that the fundamental right of self-determination must apply to all significant life decisions, including what is perhaps the most intimate and personal decision of all, whether to hasten impending death if their conditions become terminal and they are suffering intolerably.

The two *Amici* organizations represent people who have AIDS, some of whom are in the terminal phase of their illnesses. The Lambda Legal Defense and Education Fund is a national non-profit public interest legal organization working for the civil rights of people with HIV and AIDS. The Gay Men's Health Crisis is the oldest and largest not for profit AIDS organization providing services to people with AIDS and their loved ones, educating the public and advocating for fair and effective AIDS policies. These organizations contend that the state should not be allowed to prohibit their members from receiving the assistance of their physicians in ending their lives when they have decided that life is no longer bearable.

[1] Amici were granted consent to file this brief.

The individual *Amici* are leaders in the disability community or prominent individuals with disabilities. Evan Davis is a partner with a major national law firm who had polio at age five. Hugh Gallagher is one of the leading historians on disability in this country. Michael Stein is the former President of the National Disability Bar Association. Barbara Swartz is a professor who has kidney disease. Susan Webb is the director of an independent living center for people with disabilities and an elected member of a national disability rights organization. All have disabilities but not terminal illnesses, and believe that they should have the right to hasten their death should they ever become terminally ill. Their personal statements are attached as an appendix to this brief.

Amici believe that the Constitution guarantees people with terminal illnesses the right to end their lives in a manner that allows them to maintain personal dignity. The attempt of Petitioners and their *amici* to use disability to justify state deprivation of this fundamental right is deeply offensive to *Amici* and the thousands of people with disabilities they represent.

A. The Disability Rights Movement

The disability rights movement is a social movement with the goal of achieving independence and autonomy for people with disabilities in all aspects of their lives. Gerben DeJong, *Independent Living: From Social Movement to Analytic Paradigm*, 60 Arch. Physical Med. Rehab. 435 (1979).[2] Judy Heumann, one of the pioneers of the movement, co-founder of the World Institute on Disability and currently the Assistant Secretary for Special Education and Rehabilitation Services at the U.S.

[2] The terms "disability rights movement" and "independent living movement" are often used interchangeably by members of the disability community. Whether they are two separate social movements or two names for basically the same movement is a matter of debate. For purposes of this brief, the broader term "disability rights movement" is used to refer to both.

Department of Education, expressed the driving spirit of the movement best in an early policy report:

> To us, independence does not mean doing things physically alone. It means being able to make independent decisions. It is a mind process not contingent upon a "normal" body.

Susan Stoddard Pflueger, *Independent Living: Emerging Issues in Rehabilitation*, foreword ii (December, 1977) (unpublished report on file with the Institute for Research Utilization).

Similarly, Edward V. Roberts, one of the founding fathers of the movement, made the following observation:

> I believe that the basic premise of the ... movement is that everyone has potential to live more independently. Our experience shows that **even the most severely and profoundly disabled individual can be independent – they may need all kinds of help – But that they can be in control of their lives.**

Id. at 1 (emphasis added).

Over time, the movement has been successful in altering the general belief in our society that people with disabilities are invariably vulnerable, exploitable, and incapable of making decisions that fundamentally affect their lives. Until recently, however, most people with disabilities accepted the predominant paternalism concerning disability and the control of their lives by other people, often to their detriment. It was only after three decades of political struggle, with the bipartisan enactment of The Americans with Disabilities Act of 1990 (the ADA)[3] that our nation developed a consensus that competent adults with disabilities can and should exercise control of their lives in the mainstream of our society.[4]

Among the rights that the movement has secured for people with disabilities are the right to live in the community, as opposed to in isolated, degrading and disempowering institutions, *Youngberg v. Romeo*, 457 U.S. 307 (1982); the right to be free of involuntary sterilization, *Relf v. Weinberger*, 372 F. Supp. 1196 (D.C.D.C. 1974), the right to raise a child, *In re Marriage of Carney*, 598 P.2d 36 (Cal. 1979); the right to have access to public streets, public transportation, schools, public services, privately owned places of public accommodation and places of employment, 42 U.S.C. §§ 12111-12181; and the right to a free and appropriate education, 20 U.S.C. § 1400 *et seq.* (1991).[5]

Entirely consistent with these rights is the right to control one's death when it is imminent – arguably the most fundamental right of all.

B. The Views of People with Disabilities

According to a major public opinion poll, 66 percent of people with disabilities support the right to assisted suicide, as compared with 70 percent of the general population. Louis Harris and Associates, Harris Poll no. 9, Table 105 (1995). This result is corroborated by a recent study which found that 63 percent of people with AIDS support this right, and 55 percent actually have considered this option for themselves. William

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[3] The Americans with Disabilities Act of 1990, 42 U.S.C. § 12101 et seq. (1990).

[4] *See generally*, Jane West, ed., THE AMERICANS WITH DISABILITIES ACT: FROM POLICY TO PRACTICE (1991); Jane West, ed., IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT (1996); Mark Nagler, PERSPECTIVES ON DISABILITY (2nd ed. 1993); Lawrence O. Gostin & Henry A. Beyer, eds., IMPLEMENTING THE AMERICANS WITH DISABILITIES ACT: RIGHTS AND RESPONSIBILITIES OF ALL AMERICANS (1993).

[5] The Individuals with Disabilities Education Act (IDEA).

Breitbart, et al., *Interest in Physician-assisted Suicide Among Ambulatory HIV-Infected Patients*, 153 Am. J. Psychiatry 238 (1996). Another study found that 90 percent of people with AIDS support the right. Brett Tindall et al., *Attitudes to Euthanasia and Assisted Suicide in a Group of Homosexual Men with Advanced HIV Disease*, 6 J. Acquir. Immune. Defic. Syndr. 1069 (1993).

While resolution of this issue by a poll of those most affected would quickly end criminalization of assisted suicide, constitutional issues are not rightly settled by popular vote. The personal and religious views of those who support either side of this national debate are immaterial to the question of whether patients who are terminally ill have a constitutional right to receive such assistance. However, the experiences and treatment realities of those who have lived with disabilities, including cancer and AIDS, are relevant to the Court's analysis. These experiences provide an explanation of why a decision, and request for assistance in accelerating death, is a legitimate treatment option which merits Fourteenth Amendment protection.

The experiences of those involved in the treatment of AIDS are particularly illustrative. Since the beginning of the AIDS epidemic in the early 1980s, people with AIDS and their advocates and service providers have been committed to ensuring that an individual with AIDS has as much autonomy in his or her life as possible. Many living with this disease have been involved decision makers in each stage of their treatment. In striving to maintain control over their lives as their physical conditions deteriorate, they have made increasing use of legal planning documents such as health care proxies and powers of attorney to maintain control of their final days. The right to end their lives with the assistance of their physicians is a natural extension of their efforts to maintain autonomy. The state's intrusion, effectively forcing a person to continue living against his or her will, destroys the autonomy that has been central to the struggles of people with disabilities.

Based on their experiences, it is clear that people with disabilities, like the public at large, believe that the state should

not be allowed to interfere with a terminally ill individual's personal decision of how and when to die. This important fact has been obscured by the vocal minority of those disability leaders who adamantly oppose recognition of the right to assisted suicide. Given the above statistics and the hard-fought battle for people with disabilities to win their autonomy, it is anomalous that some, purporting to represent the interests of people with disabilities, are advocating in favor of the state's right to interfere with the individual's autonomy.

In essence, those disability rights advocates opposing the right to assisted suicide appear to be saying that the individual with a disability should have control over every decision in his or her life, except for the decision of whether to live in the face of a terminal illness. This blatant contradiction is glaring and unacceptable to a substantial majority of people with disabilities.

C. The Interests of People with Disabilities

The interests of *Amici* are similar to the interests of millions of people with disabilities throughout this country. Although the personal circumstances of people with disabilities vary substantially, they share a common interest in maintaining control over their lives, including the ability to choose a dignified death.

The disabilities of some individuals, such as the individual *Amici*, will never be life-threatening or reach a terminal phase. To these individuals, issues concerning assisted suicide are the same as those for anyone else, except that some have a greater physical need for assistance. Like people without disabilities, these *Amici* want the right to make this choice for themselves if they someday become terminally ill. They do not want to be deprived of this right simply because they have disabilities. Nor do they want their disabilities to be used by others to justify a wholesale denial of this right.

Other individuals have disabilities which are more likely to become life-threatening, such as the individuals with AIDS represented by the two *Amici* organizations. For these *Amici*, the issue of whether there is a right to obtain physician assistance in

hastening death has a more immediate and direct impact. *Amici* in this situation want to be able to retain autonomy in making decisions about whether or when to end irreversible suffering if their illness or disability enters a terminal phase.

All *Amici* have a significant interest in how this issue is resolved. While not all are certain whether they would ever decide to hasten their own deaths, all want the freedom of knowing that this option will be available if the worst were to occur. Further, they want the security of knowing that they can exercise this option safely, effectively and legally with professional assistance. *Amici* believe that this would be a uniquely personal, moral and religious decision, one that would primarily impact themselves and their loved ones -- a decision that they should have the right to make for themselves without undue state interference.

In his personal statement, *Amicus* Evan A. Davis expresses concern that this Court may be misled by disability organizations claiming recognition of a right to die with the assistance of one's physician would harm people with disabilities. He points out:

> The narrow issue before this Court is whether a terminally ill person whose death is inevitable and imminent has a right to die with dignity. Thus this case concerns only circumstances where life is already ebbing out and the natural process of death has already begun. In these circumstances I do not want myself or any others to be deprived of an ability to die with dignity because of arguments about the interests of people with disabilities that are not accurate or germane.

Personal statement of Evan A. Davis.

II. SUMMARY OF ARGUMENT

Like others in our society, people with disabilities wish to define their concept of existence, and to have autonomy over the uniquely personal decisions that effect their lives. Unlike most

other people, many of their basic rights have been denied until very recently. After having fought for their rights for so long, and having achieved recognition through enactment of the ADA as citizens fully capable of autonomy, they are offended that, on the basis of their disabilities, others are attempting to deny them and all other Americans the right to end their lives with dignity if they become terminally ill.

People with terminal illnesses have a liberty interest under the Fourteenth Amendment to end their lives with the assistance of their physicians, if they so choose. This liberty interest must be considered fundamental. It is at least as strong as other liberty interests recognized by this court, such as the right to terminate life support. Specifically, the current cases involve the right of an individual who is acutely aware of his or her suffering and impending death, and whose decision to hasten death by a few days or weeks does not harm the interests of any other person or potential person.

Assuming that the right is fundamental, the blanket prohibition in this case denying the right to all terminally ill individuals is not a narrowly tailored restriction necessary to achieve a compelling state interest. In fact, there is no compelling state interest in denying a person who is suffering and has little life left from ending his or her life with dignity. Any interests that the state has in denying the right are significantly outweighed by the interests of the individual. All legitimate state interests, such as ensuring competence, preventing coercion, and avoiding abuse, may be achieved through state regulation that does not unduly interfere with the basic right.

All objections raised by members of the disability community who oppose recognition of the right are either misplaced or may be addressed through appropriate regulation. Contrary to their assertions, neither the liberty interest in hastening death with physician assistance nor the diminished state interest in preventing this from occurring is in any way based upon quality of life considerations being imposed on the individual. It is derived from the autonomy of terminally ill

individuals to determine whether they wish to continue to live with their suffering for the brief remainder of their lives.

Moreover, any objections based on the Equal Protection Clause and the ADA lack merit. Terminally ill individuals are not similarly situated to people who are not terminally ill. They are dying, soon and often in great pain, and the right to end their suffering and control their deaths is a significant benefit to them. Giving them that respect does not deny them the protection of the state and does not discriminate against them in any way.

In contrast, as the Second Circuit found, competent, terminally ill individuals are similarly situated to people on life support who, when competent, indicated that they did not wish to live under those circumstances. Denying terminally ill individuals the right to assisted suicide violates the Equal Protection Clause.

In a compassionate society that respects the autonomy of people with disabilities, we must not deny people with terminal illnesses the right to end their suffering. For these individuals, physician assistance is the only means by which to ensure that their lives will end in a safe and humane manner.

III. ARGUMENT

A. PEOPLE WITH DISABILITIES ASSERT THAT PEOPLE WITH TERMINAL ILLNESSES HAVE A CONSTITUTIONAL RIGHT TO HASTEN INEVITABLE DEATH WITH THE ASSISTANCE OF THEIR PHYSICIANS

1. Competent, Terminally Ill Adults Have a Strong Liberty Interest Under the Fourteenth Amendment in Making End-of-Life Decisions Free of Undue Government Interference[6]

Because of the long struggle for recognition of their autonomy, the Fourteenth Amendment's Due Process limitations on the state's ability to intrude into the most important and personal matters of our lives has particular importance to people with disabilities. *Amici* agree with the Ninth Circuit that there is a liberty interest in determining the time and manner of one's death, and that "[c]ertainly, few decisions are more personal, intimate or important than the decision to end one's life, especially when the reason for doing so is to avoid excessive and protracted pain." *Compassion in Dying v. State of Washington*, 79 F.3d 790, 813 (9th Cir. 1996).

Amici further agree with the Ninth Circuit's application of *Planned Parenthood v. Casey*, 505 U.S. 833 (1992) (*aff'g Roe v. Wade*, 410 U.S. 113 (1973)) and *Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261 (1990)). The right to "define one's own concept of existence," found in *Casey*, 505 U.S. at 851, and to

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[6] Although the Ninth Circuit decided this case on the basis of a Fourteenth Amendment liberty right, and this brief will focus on that right, Amici believe that there are additional bases for finding a right to assisted suicide. In particular, they contend that there is a strong privacy right in the Constitution for people with terminal illnesses to be protected from state intrusion. As Justice Brandeis stated in his famous dissent in *Olmstead v. United States*, 277 U.S. 438, 478 (1928), the framers of the Constitution "conferred, as against the government, the right to be left alone--the most comprehensive of rights, and the right most valued by Civilized men." In addition, at least one commentator has argued that a Fourteenth Amendment property right in one's body precludes state prohibition of assisted suicide. Roger F. Friedman, *It's My Body and I'll Die if I Want To: A Property-Based Argument in Support of Assisted Suicide*, 12 J. Contemp. Health L. & Pol'y 183 (1995).

have autonomy over the "uniquely personal decisions" that affect their lives, found in *Cruzan*, 497 U.S. at 281, are extremely important to people with disabilities. Where for generations, almost every aspect of their existence was defined by a paternalistic society that labeled them inferior and relegated them to institutions, they are unwilling to relinquish their autonomy.

This Court has previously found that a liberty interest is implicated when an individual is subject to state-imposed pain and suffering, even when such pain and suffering involves no more than a student being paddled for disciplinary purposes. *Ingraham v. Wright*, 430 U.S. 651, 674 (1977). In the current cases, the states are effectively forcing terminally ill individuals to incur severe pain and suffering. The state's interest in preventing the individual from escaping this anguish is minuscule.

The liberty interest asserted here is also no less compelling than that in *Cruzan*, where this Court recognized a competent individual's liberty right to refuse medical treatment and obtain active medical assistance in withdrawing existing treatment even when this will result in death. *Cruzan*, 497 U.S. at 261. Here, Respondents and *Amici* seek recognition of a right for terminally ill individuals to obtain medical assistance that will likewise cause death. While Nancy Cruzan could have lived for years unconscious on life support, the individuals in this case were fully conscious of their brief remaining life, their pain and suffering, and their desire to end their suffering.

2. The Second Circuit Implicitly Agreed With the Ninth Circuit That There is a Liberty Interest for People with Disabilities (and Other Individuals) With Terminal Illnesses in Hastening Their Own Death

Although the Second Circuit decided *Quill v. Vacco*, 80 F.3d 716 (2nd Cir. 1996), based on the Equal Protection Clause of the Fourteenth Amendment, it is clear from its language that there is a due process liberty interest in deciding when and how to die. *Quill*, 80 F.3d at 725. In discussing "the protection of minorities,

the poor, and the non-mentally handicapped," the court concluded that "[i]n point of fact, these persons themselves are entitled to hasten death by requesting [withdrawal of life support] **and should be free to do so by requesting appropriate medication to terminate life during the final stages of terminal illness.** *Quill*, 80 F.3d at 730 (emphasis added).

As one commentator concluded, "[t]he Second Circuit ...says that no such liberty interest exists, yet in effect bases its Equal Protection Clause analysis on the existence of just such an interest." Christopher N. Manning, *Live and Let Die? Physician-Assisted Suicide and the Right to Die*, 9 Harv. J.L. Tech 513, 515 (1996). Thus, while certiorari was granted in this case in part due to differences in the reasoning of the two Circuit courts, there seems to be greater agreement between the Circuits that there is a liberty right to assisted suicide than is apparent from the Second Circuit's holding.

3. The Liberty Interest Asserted Here Is Fundamental and May Not Be Impaired Without a Compelling State Interest

These cases are about the ability of a terminally ill individual to die with dignity; however, they are equally about whether we, as a society, believe that the state should be allowed to impose itself at the patient's deathbed, between the patient, family members and the physician, as an equal medical decision maker. They are about whether terminally ill individuals are accorded the respect they deserve in making what may be the most difficult decision of their lives, and whether the state may incarcerate their physicians for honoring their request.

Amici believe that the ability of the state to intrude in and interfere with the final wishes of a dying person is unacceptable in a free society. They contend that the decision of terminally ill individuals to select the time and manner of their deaths cannot be infringed upon by a state without a compelling state interest that is achieved through a narrowly-tailored restriction. *Reno v. Flores*, 507 U.S. 292, 301-02 (1993). *Amici* agree with Justice Stevens, who in his dissent in *Cruzan*, concluded "[c]hoices about

death touch the core of liberty. Our duty, and the concomitant freedom, to come to terms with the conditions of our own mortality are undoubtedly "so rooted in the traditions and conscience of our people as to be ranked as fundamental..."[7] *Cruzan*, 497 U.S. at 343 (emphasis added).

4. There is No Compelling State Interest in Denying Terminally Ill Individuals the Right to Die, and the Liberty Interest of the Individual Substantially Outweighs Any State Interests

If this Court finds the interest being asserted here is fundamental, as *Amici* contend, any restriction on pursuing that interest must be narrowly tailored to further a compelling state interest. *Reno*, 507 U.S. at 301-02. The restrictions being considered are not narrowly tailored; they fully preclude individuals from obtaining the assistance of their physicians in hastening their death. Moreover, there is no compelling state interest that would justify the denial of the final wish of a suffering terminally ill individual to end his or her life with dignity.

If, on the other hand, this Court finds the interest asserted is only important, it must be balanced against other relevant state interests. *Cruzan*, 497 U.S. at 279; *Youngberg*, 457 U.S. at 321. After an exhaustive analysis of all relevant state interests, the Ninth Circuit found that the balance weighs heavily in favor of the individual. *Compassion in Dying*, 79 F.3d at 799. *Amici* agree with this analysis, and wish to add only that the interests of the state in protecting competent people with terminal illnesses (or people with other disabilities) is no greater than its interest in protecting other competent individuals.

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[7] Justice Stevens further found that "... not much may be said with confidence about death unless it is said from faith, and that alone is reason enough to protect the freedom to conform choices about death to individual conscience." *Id.* *Amici* strongly agree. *See* Statement of Amicus Evan Davis.

Amici recognize the legitimate interest of the state in protecting and preserving life. The interest in protecting life is best furthered by ensuring that the decision to end life with the assistance of a physician, is made voluntarily, by a competent, terminally ill individual. The state always has this interest and may pursue it through effective regulation.

However, the state's interest in *preserving* life diminishes, and the interest of the individual to be protected from state intrusion increases, as the potential for life diminishes. *In Re Quinlan*, 355 A.2d 647 (N.J. 1976), *cert. denied sub nom* 429 U.S. 922 (1976). *Garger v. New Jersey*, 429 U.S. 922 (1976). The interest of the terminally ill individual in ending his or her suffering far exceeds that of the state in preserving what little life remains.

While *Amici* recognize the legitimate interests of the state in protecting individuals from the actions of others, they and the majority of people with disabilities in this country do not want the protection of the state from their own actions and decisions.

5. The Legitimate State Interest in Protecting People with Terminal Illnesses or Other Disabilities from Abuses Can Be Protected Through State Regulation

The state has a legitimate interest in ensuring that all individuals who seek physician assisted suicide are competent adults who have made their decision voluntarily, without coercion or undue influence. In addition, the state may legitimately seek to ensure that the individual has had access to medical or psychological counseling and is fully aware of his or her options. *See* personal statement of *Amicus* Barbara Swartz.

A state may enact rules to protect state interests so long as they do not impose an undue burden "with the purpose or effect of placing a substantial obstacle in the path of" the ability to make the constitutionally protected decision. *Casey*, 505 U.S. at 877. In the context of physician assisted suicide, the state may not regulate with the purpose or effect of placing a substantial

obstacle in the path of a terminally ill individual to end his or her life with the assistance of a physician.

There are, however, clear measures a state might take to protect its legitimate interests. In particular, as long as it does not cross over the substantial-obstacle line, a state might impose the following safeguards:

- requiring the individual to repeat the request on more than one occasion;
- requiring the request to be made to more than one doctor;
- requiring the individual to be provided an opportunity to discuss the decision with a mental health professional;
- requiring the individual to be informed of programs and resources that are available to improve the quality of his or her remaining life; and
- requiring the individual to be informed on several occasions that he or she may, and is encouraged to, change his/her mind at any time.

These illustrate several of the requirements a state would be allowed to impose to protect its legitimate interest in ensuring competent, voluntary decisions and preventing coercion to choose hastened death. In addition, states may require hospitals, nursing homes, and other medical institutions to report on their compliance with these requirements.

Amici are committed to ensuring that the right of terminally ill individuals to obtain physician assistance in dying with dignity is not abused, that all individuals who choose to hasten their deaths do so freely, without pressure or coercion, and that they are aware of available options should they choose to continue to live. *See* personal statement of *Amicus* Susan Webb.

B. THE RIGHT TO ASSISTANCE IN DYING WILL BENEFIT PEOPLE WITH TERMINAL ILLNESSES, AND WILL NOT ADVERSELY AFFECT OTHER PEOPLE WITH DISABILITIES

1. Neither the Strong Liberty Interest in Hastening Death, Nor the Diminished State Interest in Interfering With This Decision, Are Based on Any Externally-Imposed Quality-of-Life Considerations

Some disability organizations that oppose the right to assisted suicide contend that the right is based on a social perception that people with terminal illnesses and other disabilities have a diminished quality of life. This contention is inaccurate. The strong liberty interest of terminally ill individuals in controlling the circumstances of their deaths, and the diminished state interest in interfering with this decision, are derived from their autonomy in making decisions about what little remains of their lives.

The interests do not derive in any way from any perceived diminished quality of life for individuals with disabilities or terminal illnesses. Quality of life is a subjective valuation belonging to the individual, not the courts or the states. Whether the quality of the life remaining for a terminally ill person is sufficient to justify whatever pain and suffering he or she may be enduring is a decision for that person, and that person alone.

2. The Right to Hasten Inevitable Death is a Benefit for People with Terminal illnesses That is Not Prohibited By Either the Equal Protection Clause or the Americans with Disabilities Act.

Some opponents of the right argue that it would deprive people with disabilities of the equal protection of the laws and would otherwise discriminate against them in violation of the ADA. These arguments are based on a fundamental

misunderstanding of the right. They characterize the benefit to terminally ill individuals of a right to hasten their own death as the discriminatory denial of a statutory right to be protected from their own decisions to end their lives. Regardless of this flip-flopped reasoning, the majority of people with disabilities regard the right to death with dignity as a benefit, not a legal detriment.

The Equal Protection Clause of the Fourteenth Amendment commands that no state shall "deny to any person within its jurisdiction the equal protection of the laws," which essentially means that all persons who are similarly situated should be treated alike.[8] *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 439 (1985). The threshold question is whether people with terminal illnesses are similarly situated to non-terminal individuals with respect to their interest in dying. The answer is clearly no. Terminally ill individuals who are at the end of their lives, often with severe pain and suffering, have a different interest in end-of-life decisions than others.

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[8] It is currently not clear what standard of review should apply to legislative classifications based on disability for purposes of equal protection analysis. On the one hand, the Supreme Court clearly found that people with mental retardation (perhaps the most vulnerable group in the disability community) are not entitled to heightened scrutiny. *Cleburne*, 473 U.S. at 422. On the other hand, *Cleburne* was decided in 1985, prior to the Congressional finding in the enactment of the ADA that "individuals with disabilities are a discrete and insular minority who have been faced with restrictions and limitations, subjected to a history of purposeful unequal treatment, and relegated to a position of political powerlessness in our society based on characteristics that are beyond the control of such individuals . . .." 42 U.S.C. § 12101(a)(7). Based on this finding, this Court may find that legislative classifications based on disability must receive the highest level of scrutiny. *Cf. Trautz v. Weisman*, 819 F. Supp. 282 (S.D.N.Y. 1993). Whichever standard this Court decides to apply, the right of terminally ill individuals to end their lives does not violate the Equal Protection Clause for reasons discussed herein.

Moreover, given the nature of the right at issue here, it is more appropriately viewed as an interest held by all individuals that may be exercised as a right if and when they become terminally ill, rather than a right held by terminally ill individuals and not others. Terminal illness, like disability generally, does not discriminate; it may affect anyone. Denying people who are not terminally ill the right to end their lives with physician assistance, until such time that they become terminally ill, does not deny them equal protection.

The second question is whether the right to assisted suicide deprives people with terminal illnesses of a benefit that is available to other individuals. Again, the answer is no. The right being asserted here would give terminally ill individuals an additional choice that they currently do not have. It would not require them in any way to exercise that choice. It would not deprive them of life. It would not deprive them of protection from murder. It would not deprive them of state suicide prevention services. In fact, it would not deprive them of anything.

The ADA prohibits actions by or policies of public entities that "exclude from participation in" or "deny the benefits of" any program, service, or activity of a public entity or by which persons are "subjected to discrimination by any such entity." 42 U.S.C. § 12132. Again, the right being asserted does not deny any benefit to any person with a disability, nor does it exclude any person with a disability from participation in any state program, service or activity.[9] The ADA was not intended to

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[9] The one way in which the ADA may be applicable, however, is with respect to individuals with terminal illnesses who are not capable of self-administration of the lethal drug. Certain people with disabilities, such as some people with quadriplegia, have physical limitations which severely restrict or render impossible the ability to self-administer drugs. Modern technology has resolved this issue for the vast majority of these individuals through the development of assistive devices that allow them to self-administer. However, to the extent that

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prevent people with disabilities from having greater options than other people, particularly when they are entirely free not to exercise those options.

Moreover, the ADA was not intended to protect people with disabilities from their own decisions. One form of discrimination against people with disabilities explicitly mentioned as a basis for the ADA is "overprotective rules and policies." 42 U.S.C. § 12101(5). Terminally ill individuals have a particularly strong liberty interest in not being "protected" by the state from their own end of life decisions. The right to obtain physician assistance to hasten their death is a significant benefit to them. They do not want protection from this choice.

3. The Standard of Terminal Illness Will Allow States to Prevent People Who Are Not Terminally Ill from Ending Their Lives With Physician Assistance

Some disability organizations that oppose assisted suicide contend that this right inevitably will be expanded to people with disabilities who do not have terminal illnesses. There is no reason this will occur. The requirement that the individual seeking to end his or her life must have a terminal illness that makes death imminent and inevitable is readily capable of definition and implementation. Many states and model codes define the term "terminal illness." Brief of Respondents *(Glucksberg)* at 32.

The fact that there is no uniform definition for "terminal illness" is of little consequence. At this stage, we need only consider the broad parameters of the right. In the current cases,

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9(...continued)
some of these individuals who are terminally ill are incapable of self-administration even with an assistive device, the ADA would probably require that the individual be permitted the assistance of his or her physician in administering the drug. Such administration would be entirely consistent with the active role that physicians currently play in conducting abortions and in terminating life support systems.

all people with terminal illnesses are precluded from obtaining the assistance of their physicians in ending their lives. This blanket prohibition clearly violates the liberty rights of many individuals who are, without any doubt, terminally ill. As long as a state defines terminal illness within the bounds of reasonableness, it may prevent people who fall outside those bounds from obtaining assistance in dying.

Some opponents point to the Netherlands as proof that the right to physician assisted suicide cannot be contained to people with terminal illnesses. Any such comparison is misleading. In the Netherlands, physician-assisted suicide is not allowed by statute, but physicians who adhere to official guidelines will not be prosecuted for assisting patients who request assistance in dying. However, those guidelines have never required that the patient be terminally ill or that the patient's suffering be physical. Chris Docker, *Euthanasia in Holland*, ¶ 1 (1996) <http://www.euthanasia.org/ dutch.html>.

Two recent studies of doctor-assisted death in the Netherlands suggested that tolerance of the practice has not produced the "slippery slope" leading to abuses which critics have predicted. P.J. van der Mass, et al., *Euthanasia, Physician-Assisted Suicide and Other Medical Practices Involving the End of Life in the Netherlands, 1990-1995*, 335 N. Eng. J. Med. 1699 (Nov. 28, 1996); G. Van Der Wal et al., *Evaluation of the Notification Procedure for Physician-Assisted Death in the Netherlands*, 335 N. Eng. J. Med. 1706 (Nov. 28, 1996); M. Angel, *Euthanasia in the Netherlands – Good News? Or Bad?*, 335 N. Eng. J. Med. 1676 (Nov. 28, 1996).

The situation in the Netherlands, therefore, provides no support for the proposition that the right limited to terminally ill individuals in our country will necessarily be expanded.

4. The Standard of Voluntariness Will Allow States to Ensure Only Competent Individuals Who Choose to Hasten Death With Assistance Are Allowed to Do So

Opponents of the right to die further assert that people with disabilities will be induced to end their lives by others who consider them inferior or a burden. However, the right asserted here is based entirely on the voluntary choice of a competent individual with a terminal illness to end his or her life. As discussed above, the state is free to enact regulations to ensure that the decision is made voluntarily by a competent adult who was not subject to coercion or undue influence. Despite such standards, opponents contend that this right will be extended to incompetent individuals. They base this conclusion on case law concerning the right to refuse life-sustaining medical interventions. However, such expansion is by no means inevitable and may be precluded by this Court's decision.

The liberty right to assisted suicide is different from the right to withdraw life support. While competent individuals in both situations are similarly situated for purposes of equal protection analysis, the right to withdraw life support is based fundamentally on the common law right to be free from bodily invasions. *Cruzan*, U.S. at 269. The courts have appropriately found that, like competent individuals on life support, incompetent individuals have a right to be free from such invasions. The right to assistance in dying is based on the interest of the terminally ill individual to control his or her life. Because the right is based on the autonomy of the individual, it may be limited to those individuals who are capable of autonomy–competent adults.

5. In the United States, the Right of Terminally Ill Individuals to Choose Assisted Suicide Will Never Be Converted into a Right of the State to Authorize the Murder of People with Disabilities

Some organizations that oppose physician assisted suicide for competent patients who are dying and suffering contend that this is the first step toward a society in which life is devalued and people with disabilities are routinely killed by their doctors. These groups point to the "euthanasia" program authorized by

Nazi Germany in the 1930s as a graphic example. There are several serious problems with this analogy.

First, our country is not Nazi Germany; ours is a nation dedicated to individual freedom in which the state is constitutionally limited in depriving individuals of life, liberty or property and the press is constitutionally empowered to inform the citizenry of abuses of state power. The notion that the state will have an interest in killing, or authorizing the killing of, people with disabilities is ludicrous. One could just imagine the TV coverage of such abuses on the evening news, or "60 Minutes", as well as the criminal and civil legal actions that would inevitably follow.

Second, the Nazi program did not begin by granting a right to assisted suicide for people with terminal illnesses. It began with a determination by the state that people with disabilities are inferior, have an inferior quality of life, and are therefore disposable. That determination was in fact entirely consistent with the goals and ideals of the Nazi party, and flourished when the party flourished. By contrast, the notion that people with disabilities may be killed without their consent is, and will always be, abhorrent to the American public. The false notion that they are inferior or necessarily have an inferior quality of life may never in this country serve as a basis for any public policy, particularly a policy that would deprive them of life, liberty or property. The right being sought here is not in any way based on any perceived inferiority, or inferior quality of life of, people with terminal illnesses.

Third, and most important, the state in Nazi Germany gave the medical profession unbridled power and authority to control the lives and deaths of individuals with disabilities. In current cases, Respondents and *Amici* seek to expand individual autonomy and liberty, and to diminish the power and authority of the state to make or authorize decisions concerning the life and death of an individual. The implication of recognition of a right to assisted suicide is, therefore, not that the state will have more

power to take the life of any of its citizens, with or without disabilities, but rather that it will have less power.

Amicus Hugh Gallagher, author of *By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich*, and one of the world's foremost experts on the Nazi euthanasia program, describes in his personal statement how the medical establishment in Germany, at its request, was authorized by the government to provide a "mercy" death for patients who in the judgment of their physicians had "lives not worth living," and that the patients were given no choice over whether to live or die. In indicating his support of the right to assisted suicide, he concludes that:

> The Nazi's euthanasia program offers a horrible example of how easy it is to go wrong when the state or a group authorized by the state is allowed to assume the power to judge the worth of another. Ironically, this program is now being used by some as a justification to deny Americans in the terminal stage of illness the right to die with assistance. In fact, the German experience shows how important it is that the autonomy of people with disabilities be honored in all aspects of their lives. . . .
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> The case of assisted suicide is quite different: the patient with a terminal illness retains complete choice over whether to live or to die. Neither the state nor the physician may decide, based on their conceptions of the individual's quality of life; the individual must assess his or her own quality of life. This is true whether or not the individual has a disability....
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> To my mind, the issue comes down to control -- control over one's Self. This control over Self is the very heart of the disability rights struggle. In Nazi Germany 60 years ago, people with disabilities were deprived of all control over their Selves. They were killed not because they sought death but because they did not measure up to "quality of life" standards set

> by their physicians with the concurrence of the state. This must never happen here.

Personal statement of Hugh Gregory Gallagher.

C. DENIAL OF THE RIGHT TO ASSISTANCE IN DYING WOULD DENY PEOPLE WITH TERMINAL ILLNESSES THE EQUAL PROTECTION OF THE LAWS

While the people with terminal illnesses in these cases are not similarly situated to people who are not terminally ill for purposes of the Equal Protection Clause, they are similarly situated to competent people on life support who have clearly indicated that they do not wish to live under such circumstances. *Amici* agree with the decision of the Second Circuit that "New York does not treat similarly circumstanced persons alike: those in the final stages of terminal illness who are on life-support systems are allowed to hasten their deaths by directing the removal of such systems; but those who are similarly situated, except for the previous attachment of life-sustaining equipment, are not allowed to hasten death by self-administering prescribed drugs." *Quill*, 80 F.3d at 729. *See*, personal statement of *Amicus* Barbara Swartz.

D. A COMPASSIONATE SOCIETY THAT RESPECTS PEOPLE WITH DISABILITIES MUST NOT DENY TERMINALLY ILL INDIVIDUALS THE RIGHT TO END THEIR SUFFERING WITH ASSISTANCE

People with terminal illnesses have an immediate and urgent liberty interest in the right to hasten their death with the assistance of their physicians, whether or not they decide to exercise that right. Diseases such as cancer and AIDS may cause great pain and suffering, physical deterioration, and mental anguish. A society that cares about these individuals and that respects their autonomy must not deny them the opportunity to shorten the period of their suffering and to die with dignity in a safe and effective manner, with the assistance of their physicians.

1. The Decision of a Competent, Terminally Ill Individual to End His or Her Life Must Be Assumed to Be Rational and Should Be Respected

In our legal system, the decisions of competent individuals are presumed to be rational.[10] This presumption applies to the decisions of people with disabilities, and any contrary assumption by a state in establishing its policy would violate the ADA and our national policy concerning people with disabilities. Therefore, a state may not assume that the decision of a competent terminally ill individual to end his or her life is irrational and may not base a policy precluding assisted suicide on such an assumption.

Yet, some disability rights advocates who oppose the right to die seem to argue that people with disabilities are not capable of autonomy for purposes of determining when and how they should die when facing death with a terminal illness. The reason for this apparent inconsistency with their basic philosophy is that, they contend, many people with disabilities have so few resources or viable options that they cannot make a rational choice to end their lives. This inconsistency is unacceptable to *Amici* and the majority of people with disabilities.

Amici are leaders in the disability community who are committed to improving the lives of all people with disabilities and to enhancing the options available to them. They agree that our society often does not provide the support necessary for people with disabilities to live independently in their communities. However, the fact that the circumstances of the disabled population are, as a whole, far less than ideal in this country, and are likely never to be perfect, is no justification for depriving those who have a terminal illness of the right to end their suffering. These individuals are entirely capable of making rational decisions. *See* personal statement of Susan Webb.

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[10] *See, H.L. v. Matheson*, 450 U.S. 398, 453 (1951); *Davis v. United States*, 160 U.S. 469, 477 (1895).

As indicated above, between 66 and 90 percent of people with AIDS support the right to assisted suicide. Significantly, the study that found that more than half (55 percent) have considered this option for themselves, also found that the strongest predictor of interest in physician assisted suicide was having witnessed terminal illness in a family member or friend. Breitbart, *supra* at 242; Tindall, *supra* at 1069. This suggests that these individuals know from personal experience the pain and suffering a terminal illness can impose, and have concluded that a person should have the right to end that agony if they so choose. According to one observer:

> Patients who are dying of cancer and wish to lessen their suffering raise the concept of rational suicide. They are competent to make decisions, feel that they have completed their contribution to the world, and are unlikely to contribute anything more in the few weeks remaining. The disease is advanced and advancing, and they understand and accept it. Estimates of survival are in weeks rather than months, and they are quite willing to relinquish the possibility of another remission. They do not believe in miracles. Indeed, their condition may be so pitiful as to command the sympathy of family, friends and caregivers alike. The only desire is to shorten the process of dying and terminate the suffering.

Charles F. McKhann, *Is There a Role for Physician-Assisted Suicide in Cancer? Yes*, Important Advances in Oncology, 267, 269 (1996).

2. Recognition of the Right to Receive Physician Assistance Will Serve to Ensure Safety and Curtail Abuse

As was true with abortion in the years before this Court's decision in *Roe v. Wade*, the continued criminalization of physician assisted suicide has not stopped many physicians from aiding competent patients to end their suffering. *See* Jody B. Gabel, *Release From Terminal Suffering? The Impact of AIDS on*

Medically Assisted Suicide Legislation, 22 Fla. St. U.L. Rev. 369, 372-73 (1994); L. Slome, J. Moulton, C. Huffine et al., Physicians' attitudes toward assisted suicide in AIDS, 5 J. AIDS 712-18 (1992); Dick Lehr, *Death & the Doctor's Hand, Increasingly, Secretly, Physicians Are Helping the Incurably Ill to Die*, Boston Globe, Apr. 25, 1993 at 1.

In the face of legal prohibitions on physician assistance, others are coming to the aid of the dying. One recent study surveyed 1139 critical care nurses in the United States, of which 71 percent practiced exclusively in intensive care units for adults. Of that group, 17 percent reported requests from patients or family members for euthanasia or assistance in suicide;[11] 16 percent of those asked, did so. An additional 4 percent stated they had hastened a terminally ill patient's death by pretending to provide life-sustaining treatment ordered by a physician. David Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374-79 (May 23, 1996).

One California study of persons caring for loved ones with AIDS found more than 10 percent of these caregivers reported giving drugs to hasten their loved ones' death. M. Coode, L. Gourlay, L. Collette et al., *Dying of AIDS: The Role of Caregivers in Terminal Care and Hastened Death*, Center for AIDS Prevention Studies, University of California, San Francisco, Paper presented at the 10th International Conference on AIDS, Yokohama, Japan, August, 1994.

The ban on assisted suicide has simply ensured that persons lacking the requisite training will continue to intervene on behalf of those wishing to die. A desperate individual left to his or her own devices may likewise be forced to resort to whatever means are available to curtail suffering, such as "hanging, suffocation or shooting." Jeremy A. Sitcoff, *Death with Dignity: AIDS and a Call for Legislation Securing the Right to Assisted Suicide*, 29 J.

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[11] David A. Asch, *The Role of Critical Care Nurses in Euthanasia and Assisted Suicide*, 334 N. Eng. J. Med. 1374-75 (1996).

Marshall L. Rev. 677, 687 (1996). Without physician assistance, the consequences may be other than intended, potentially resulting in severe injury (e.g., coma, brain damage or increased agony). "Often, the person who has made a rational choice to die with dignity must accept his death in a totally undignified manner". *Id.*

3. People with Terminal Illnesses Should Not Be Compelled to Die in a Drug-Induced Semi-Conscious Haze

The typical treatment of people with terminal illnesses that cause great pain is to administer high levels of pain medication to the individual, which typically puts him or her in a semi-conscious state for an extended period of time. In administering this medication, the physician is fully aware that there is a significant probability of killing the patient. However, this is considered sound medical practice, while assisting an individual with the intent to help the individual end his or her life is a criminal act.

Individuals should not be forced to spend their final days in a drug-induced stupor to alleviate their pain. To many individuals, the prospect of leaving this world in such a state of prolonged semi-consciousness is a fate worse than death. In one study of eighteen patients with cancer, one patient with prostate cancer and bone metastases stated: "Who wants to suffer this kind of pain? The medication puts me to sleep. As soon as I wake up, there is the pain. If I can't live free of pain, I'm not living at all, simply existing." McKhann, *supra* at 268.

With the option of physician assisted suicide, terminally ill individuals may choose to remain fully conscious, recognizing that they may end their suffering permanently at any time. This option, therefore, allows them to spend their remaining days saying good-bye to their friends and relatives and putting their affairs in order. To them, and to most people, this dignified exit is far preferable to having their loved ones look on hopelessly as they slowly drift from drug-induced semi-consciousness to death.

4. Physician Assisted Suicide Allows People with Terminal Illnesses to Postpone Ending Their Lives Until a Later Phase of Their Illness

The recognition by people with terminal illnesses that they can end their suffering often gives them the will to continue to live. A strategy of many terminally ill individuals is to determine the point in the disease process when it would be unbearable to live and to decide to end their lives at that point. The control that this gives them over their lives often allows them to sustain a willingness to live. Many times, individuals reach the planned point and extend their self-imposed limit to a later stage of the disease. Often, they postpone the decision permanently, and die from the disease. Mary Evangelisto, *Death with Dignity: End-of-Life Issues for the HIV/AIDS Patient*, 34 J. Psychosoc. Nurs. 45, 46 (1996).

IV. CONCLUSIONS

Issues of autonomy and self-determination are at the heart of the struggle of people living with disabilities. They want to be able to control the decisions that affect their lives. Like the majority of Americans, they particularly do not want the state to deprive them of such control during their final days, if they have decided their suffering is intolerable. This decision must be made by the individual in consultation with his or her loved ones and personal physician. The state has no legitimate place interfering in this profoundly personal decision making process.

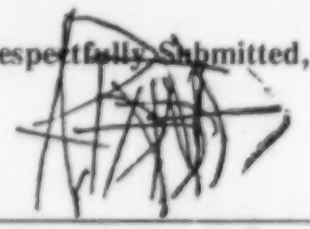
The right of terminally ill individuals to control their deaths is fundamental. There are few, if any, interests that are more basic to individual liberty, and few, if any, circumstances in which the state's interest is less. *Amici* do not want to be deprived of this right by the state simply because others, including others with disabilities, may not make this choice for themselves or because of concern over potential abuse. They do not want their disabilities to be used to justify the denial of this right to others. The interests of a dying person to control the remainder of his or her life far outweighs any state interests.

There is certainly no state interest sufficient to prohibit all people with terminal illnesses from obtaining compassionate assistance in dying from their physician.

Amici are committed to ensuring that the right to physician assisted suicide is applied fairly and appropriately. They believe that the vast majority of individuals who have available the option of physician assisted suicide will choose to live, comforted by the knowledge that the decision to continue to live is theirs and theirs alone. The enormous interest in this case by members of the disability community ensures that multitudes of disability rights advocates, including *Amici*, as well as other concerned individuals, will do everything they can to ensure this right is not abused and to encourage terminally ill individuals to choose to live.

The decision of the Ninth Circuit that people with terminal illnesses have a liberty right in ending their lives with the assistance of their physicians, and the decision of the Second Circuit that denial of this right constitutes a denial of the equal protection of the law, should be affirmed.

Respectfully Submitted,

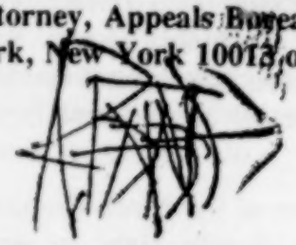


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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that true and correct copies of the foregoing were sent via U.S. mail to: William L. Williams, Deputy Senior Assistant Attorney General, Transportation and Public Construction Division, Office of the Attorney General, 905 Plum Street, Olympia, Washington 98504-0113; Barbara Billett, Solicitor General State of New York, Office of the Attorney General, The Capitol, Albany, New York 12224; and Marc F. Scholl, Assistant District Attorney, Appeals Bureau, One Hogan Place – Room 812, New York, New York 10013, on December 9, 1996.



Andrew I. Batavia

APPENDIX

PERSONAL STATEMENTS

OF

AMICI CURIAE

Personal Statement of Evan A. Davis

I am an attorney admitted to practice in the State of New York and a member of the Bar of this Court. I am a litigation partner with Cleary, Gottlieb, Steen and Hamilton in New York City. In 1949, at the age of five, I contracted polio and since then have gotten around with the help of braces, crutches and a wheelchair. For the last twenty years or so I have used the wheelchair almost exclusively. Because I received an excellent education and because my credentials are strong, this disability has not limited my practice.

I was asked to participate in this amicus brief by Professor Sylvia Law of New York University Law School. She told me that various groups representing persons with disabilities were filing amicus briefs in support of Petitioners urging that the interests of disabled people would be disserved by affirmance of the decisions below. As it happened I had just spent a good deal of time studying the legal issues now before this Court. With my knowledge of these issues in mind I agreed to participate because I thought the Court needed to be informed that if the issue before it is viewed narrowly, as it should be, affirmance would work absolutely no harm to the interests of people with disabilities.

My interest in this Court not being misled is two fold. The narrow issue before this Court is whether a terminally ill person whose death is inevitable and imminent has a right to die with dignity. Thus this case concerns only circumstances where life is already ebbing out and the natural process of death has already begun. In these circumstances I do not want myself or any others to be deprived of an ability to die with dignity because of arguments about the interests of people with disabilities that are not accurate or germane.

I also have an interest in this Court not being mislead because I believe it is uniquely the obligation of this Court under the Fourteenth Amendment to decide what is the proper scope of the citizen's right to be left alone by government in regard to seeking a dignified death. If this issue is left to the legislative process the result will likely be influenced by religious views whose sincerity I respect but which are contrary to my sincerely held religious views. Therefore I have a particularly strong interest in this Court making a sound decision on solely secular grounds based on accurate information.

Evan A. Davis

12/2/96

Date

Personal Statement of Hugh Gregory Gallagher

I am a writer and a historian. I am also a polio quadriplegic as a result of an attack of polio in 1952. For more than a decade, I have been studying and writing extensively on disability rights issues. I am particularly interested in the treatment that people with disabilities receive from the medical system. I am considered one of the foremost experts on the program authorized by Nazi Germany to "euthanize" over 200,000 of its citizens with disabilities.

The Nazi's euthanasia program offers a horrible example of how easy it is to go wrong when the state or a group authorized by the state is allowed to assume the power to judge the worth of another. Ironically, this program is now being used by some as a justification to deny Americans in the terminal stage of illness the right to die with assistance. In fact, the German experience shows how important it is that the autonomy of people with disabilities be honored in all aspects of their lives. I do not believe that people with terminal illnesses should be denied the option of ending their lives in order to obtain relief from intolerable pain and suffering. This most personal of all decisions should rest between the person and his God.

In my book, <u>By Trust Betrayed: Patients, Physicians and the License to Kill in the Third Reich</u>, I describe in detail how the medical establishment in Germany, at its request, was authorized by the government to provide a "mercy" death for patients who in the judgment of their physicians had "lives not worth living." The program was authorized by Hitler in 1939 and placed under the direction of his personal physician. Although the program was called "euthanasia," the vast majority of the people killed were not terminally ill or in great pain or even requesting death. The killings began slowly, but soon enough, entire wards were being provided "final medical treatment." The patients were given no choice over whether to live or die.

The case of assisted suicide is quite different: the patient with a terminal illness retains complete choice over whether to live or to die. Neither the state nor the physician may decide, based on their conceptions of the individual's quality of life; the individual must assess his or her own quality of life. This is true whether or not the individual has a disability.

In our generation, great strides have been made to welcome people with disabilities into society as equal members with equal rights. For the first time, people with disabilities have assumed control over their own lives, without fear of sterilization, internment, segregation and ostracism, and the denial to their rights to vote, hold property, enter legal contracts, and obtain public education, transportation and accommodation. Now they should no more be denied the right to obtain assistance in dying if they become terminally ill than should anyone else.

To my mind, the issue comes down to control -- control over one's Self. This control over Self is the very heart of the disability rights struggle. In Nazi Germany 60 years ago, people with disabilities were deprived of all control over their Selves. They were killed not because they sought death but because they did not measure up to "quality of life" standards set by their physicians with the concurrence of the state. This must never happen here.

In the United States today, we are debating whether an individual in the terminal stages of an illness should retain control over his/her Self and his/her personal concept of quality of life -- even to the point of death with dignity -- or whether such control should be circumscribed by the state.

In my own experience, it was this sense of control and the concomitant knowledge that I could end my life should the situation become unbearable, that kept me going through the extraordinary pain and suffering that accompanies acute polio. I will not turn over this control, or my personal decision to live or die, to the state. That decision is mine and mine alone.

Hugh Gregory Gallagher

Nov 28 1996

Date

Personal Statement of Barbara Swartz, Esq., In Support of Physician-Assisted Suicide

I have end-stage renal disease (ESRD) and have been considered legally disabled for the past twelve years. For eleven and a half years, I was a home hemo dialysis patient; six months ago, I had a successful kidney transplant. But I am more than a kidney patient. Professionally, I am a lawyer, a law professor and a lecturer in public health. During these past twelve years, I have been very active as a volunteer in my national kidney organization.

Throughout my career, I have been a fighter for and protector of human rights. I have worked for prisoners' rights, women's rights and patients' rights. A common theme running through these various areas is my strong commitment to the right of the individual to maintain her autonomy and dignity. In the area of patients' rights, I believe in the full and active participation of patients in our own health care decisions including end of life and death decisions. It is in making these profoundly difficult decisions that the right to individual autonomy becomes most meaningful. Competent patients already have the legal right to refuse treatment even if this decision leads to their death. In my mind, there is little legal difference between this right for a physician to help a person die with dignity, and the opportunity for a physician to prescribe medication which a competent person may choose to self-administer even though it too may lead to her death. In both cases, we are discussing the means used, either passive or proactive, to achieve the same end result. As a competent patient, I believe passionately in my right to maximum participation in one of the most intimate decisions that affects me: how I die.

I do not say that this is an uncomplicated issue and I understand that honorable people may disagree on what approach to take in cases of people wishing to die when they are in the end stages of a terminal illness. Before a physician consents to a patient's request for a lethal dose of medication, I would want to ensure that a patient is offered effective pain management and appropriate psychological assistance. Ideally, I would also like to believe that there has been an active and ongoing dialogue between the physician and the patient about this decision. But this is a matter of effective regulation rather than a strict prohibition of the practice. Ultimately, I believe that the final decision about whether to live or die must be left to the patient.

I have always been actively involved in decision making about my illness. From the onset of my kidney disease, I had to make the decision about whether to go on dialysis or not. I knew that a decision not to choose dialysis was a

decision to die. Every time I dialyzed, I made the decision to choose life over death. I also had to decide whether to put myself on the transplant list and then when a kidney was offered to me, whether to accept the offer. Each of these decisions is more comparable to a competent person's right to refuse treatment. However, I would hope that if I chose to end my life because of unbearable pain and suffering, and I needed help, I would be able to call upon my physician to assist me in dying with dignity. For me, the basic question is whose life and death is it anyway?

Barbara Swartz, Esq.

Barbara Swartz, Esq.

November 30, 1996

STATEMENT OF MICHAEL A. STEIN

I am a thirty-three year old individual who uses a wheelchair due to a childhood illness that brought about spastic paraparesis. Aside from this limitation on my mobility, I am otherwise in good physical condition and enjoy an active and healthy lifestyle.

Professionally, I teach a course on Physical Disability Law at New York University Law School while working towards completion of my Ph.D. studies in legal history at Cambridge University. Thereafter, I will return to full time law teaching and advocacy for the rights of individuals with disabilities.

In the past, I have tried to advance the status of disabled people through the publication of law review articles (See, e.g., Mommy Has a Blue Wheelchair: Recognizing the Parental Rights of People With Disabilities, 60 Brooklyn L. Rev. 1069 (1994); From Crippled to Disabled: The Legal Empowerment of Americans With Disabilities, 43 Emory L.J. 247 (1994)), editorials (See, e.g., Attitudinal Barriers to Hiring Attorneys with Disabilities, 17 Physical and Mental Disability L. Rev. 214 (1993); When Justice is Blind: Appointing Vision-Impaired Individuals to the Bench, 1 Minority L.J. 5 (1992)), service as President of the National Disabled Bar Association (1992-94), and direct lobbying of members of the United States Congress.

On a personal note, I am newly wed to a wonderful person who makes me enormously happy. In other words, I have every reason to be grateful for my existence and to want its indefinite continuation.

Nevertheless, I feel so strongly about allowing people with disabilities the option of assisted suicide, that I readily agreed to be named as party in this amicus brief. This is because, whether through illness or other circumstances, occasions arise that make some peoples' lives unbearably painful. Without the option of a facilitated passing, their existence becomes no more than an extended personal torture as they are sentenced to wait for a grim and demeaning demise. By honoring an opportunity of assistance, those people who so choose, may regain control of both their existence and their dignity.

I believe that whether an individual chooses to bring about her own demise is an intimately personal choice and should remain a private decision, protected from state regulation. The blanket prohibition against assistance in the statute at bar is invasive, eradicating a difficult decision which must be made by an individual in consultation with his conscience, family and friends.

The option of assisted suicide should be available for people who currently desire this course as well as for others, such as myself, who want a similar freedom to act in case of future circumstances.

10/29/96

Michael A. Stein

Personal Statement of Susan Webb

This statement declares my personal support of a terminally ill individual's right to die. I also support a terminally ill individual's right to die with assistance of another when it is assured that the individual has made his/her decision in writing and has made the decision after as many options for living as practicable have been made available to him/her. Under no circumstances must an individual be assisted in his/her suicide under coercion, especially by the individual who will be assisting.

Like many other persons with a disability, I have some concerns about this issue. Many persons with disabilities are relegated to institutions such as nursing homes where they feel trapped and without other options based on archaic, paternalistic systems. The only information they are given is often from persons who are not themselves disabled and who cannot fully understand the disability experience firsthand and that life with a disability can be full and rewarding.

As a disability advocate I am personally committed to working on legislation, regulations, etc. that would guarantee that individuals with disabilities have access to resources and information that might lead them to choose life instead of death. I am committed to ensuring that no one chooses death because he or she does not have adequate information with which to make an informed choice. However, once a terminally ill individual has allowed considerable time and thought, with a complete understanding of their options, the decision to end his/her life with or without assistance must be respected and implemented.

I am a person who has lived with a significant disability since 1974. As a disability advocate, executive director of an independent living center, elected board member of a national disability-rights organization and compassionate American, I make this statement from a recognized position of expertise and after much forethought. However, this statement is to be construed as a personal declaration and in no way reflects the opinions of any organization to which I belong.

Susan Webb

12-3-96

Date

FILED
SEP 2 '96
CLERK

In the Supreme Court of the United States

October Term, 1996

WASHINGTON, et al.,
Petitioners,

v.

HAROLD GLUCKSBERG, M.D., et al.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE NINTH CIRCUIT

DENNIS C. VACCO, et al.,
Petitioners,

v.

TIMOTHY E. QUILL, M.D., et al.,
Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF OF CHILDREN OF DERIVING
[illegible] IN SUPPORT OF
PHYSICIAN-ASSISTED DYING

IN SUPPORT OF RESPONDENTS

[illegible]

[illegible]

[illegible]

Nos. 96-110 and 95-1858

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ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF AMICUS CURIAE OF SURVIVING FAMILY MEMBERS IN SUPPORT OF PHYSICIAN-ASSISTED DYING - IN SUPPORT OF RESPONDENTS -

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TABLE OF CONTENTS

Page

I. STATEMENT OF AMICUS CURIAE 1

II. SUMMARY OF ARGUMENT 4

III. THE CONSTITUTION PROTECTS INTIMATE, PERSONAL, AND IMPORTANT DECISIONS INCLUDING THE CHOICE OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR A TERMINALLY ILL, COMPETENT ADULT 6

IV. DENIAL OF THE CHOICE OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR COMPETENT, TERMINALLY ILL ADULT PATIENTS IMPERMISSIBLY INFRINGES UPON THE LIBERTY INTEREST OF THE PATIENTS .. 9

A. Terminally Ill Patients Denied the Choice of Physician-Assisted Dying May Be Forced to Endure Horrific Pain and Suffering and Loss of Dignity 9

B. Terminally Ill Patients Denied the Option of Physician-Assisted Dying Are Sometimes Forced to Experience a Violent, Lonely, at Times Gruesome Death 12

C. Terminally Ill Patients Denied the Option of Physician-Assisted Dying May Be Forced to Rely on Family Members to Assist in Hastening Death 16

TABLE OF CONTENTS - Continued

Page

D. Terminally Ill Patients Denied the Option of Physician-Assisted Dying Sometimes Fail in Their Attempts to Hasten Death, with Tragic Results 22

V. DENIAL OF THE OPTION OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR COMPETENT, TERMINALLY ILL PATIENTS HAS DEVASTATING CONSEQUENCES FOR SURVIVING FAMILY MEMBERS 24

VI. THERE IS NO MEANINGFUL DISTINCTION FOR THE PATIENTS AND SURVIVING FAMILY MEMBERS BETWEEN A PHYSICIAN'S ASSISTANCE IN HASTENING DEATH AND A PHYSICIAN'S WITHDRAWAL OF LIFE SUPPORT 27

A. The Deceased Loved Ones of the Amicus Were Dying of Terminal Illnesses and Suffering in the Same Way that Terminally Ill People with Life Support Measures Suffer 27

B. The Legislatures' Distinctions Between the Refusal or Withdrawal of Life Support to Hasten Death and the Acceptance of Other Forms of Physicians' Assistance to Hasten Death is Not Rational 28

VII. CONCLUSION 29

TABLE OF CONTENTS - Continued

APPENDICES:

1 Declaration of Roberta Lau
2 Declaration of Patsy McLaughlin McGeorge
3 Declaration of Leanne Gallison
4 Declaration of Kay Beck
5 Declaration of Elvin O. Sinnard
6 Declaration of Patty Rosen
7 Declaration of Jeff (Joseph) Halsey
8 Declaration of Tania Bloom
9 Declaration of Gail Bereny
10 Declaration of Dorothy B. Hoogstraat
11 Declaration of Gösta Pearson
12 Declaration of Keith William Green
13 Declaration of William F. Meyer III
14 Declaration of Steve Knipp
15 Declaration of Jinny Tesik

TABLE OF AUTHORITIES

Page

CASES

Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996) ..... passim

Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990) 6

Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) 4,28

Planned Parenthood v. Casey, 505 U.S. 833 (1992) 6,9

Webster v. Reproductive Health Services, 492 U.S. 490, 106 L. Ed. 2d 410, 109 S. Ct. 3040 (1989) 4

OTHER AUTHORITIES

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TABLE OF AUTHORITIES - Continued

Page

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I. STATEMENT OF AMICUS CURIAE.

The amicus curiae is composed of fifteen distinct individuals--not an organization, a religious group, or a group of politicians. The amicus consists of one family member of an individual who experienced the positive aspects of physician-assisted dying and fourteen family members of individuals who experienced unnecessarily painful, traumatic deaths in the absence of physician-assisted dying. They submit this Brief in support of Respondents.[1] The family members[2] are the voices of their deceased loved ones, describing for the Court the differing realities of what happens to families when a competent, terminally ill person is granted or forbidden the choice of a hastened death. The individual experiences present the Court with the emotional resonance of dying with and without physician assistance to hasten the process. In each case, the dying person desperately wanted to hasten death--some were successful with plastic bags, some chose guns, some died slowly but naturally, in agony and without dignity, and one died when and how he wanted, under medical care, peacefully, with loved ones present. The perspective of persons who have had recent experience with this issue is relevant and necessary to the Court's proper and full consideration.

Declarations of the fifteen family members are attached hereto as Appendices 1-15.[3] The group includes a woman whose husband, dying of lung cancer, obtained medication from his physician and was able to have a peaceful and gentle death--with his wife, daughter, nurse and trained Compassion In

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[1]The parties have consented to the filing of this Brief and the letters of consent are on file with the Clerk of this Court.

[2]The term "family member" includes spouses, children, parents, and partners involved in a close personal relationship.

[3]Originals of the declarations are either on file in the Ninth Circuit case below or in the office of the counsel of record herein.

Dying volunteers at his bedside (App. 1). In juxtaposition, the remainder of the group includes:

- a widow whose husband of 25 years was compelled to shoot himself in their front yard in order to end his debilitating pain (App. 2);

- a daughter whose mother was wasted by cancer to a mere 60 pounds before she swallowed morphine (App. 3);

- a widow who helped her husband prepare the sleeping pills he would take to avoid the devastating terminal stages of esophageal cancer (App. 4);

- a husband whose wife of 49 years had to die alone with a plastic bag over her head rather than face the unbearable pain caused by a heart condition (App. 5);

- a mother who struggled to medically assist her 26 year old daughter to die, because a doctor's help was not available (App. 6);

- the partner of a man who, dying of AIDS, withheld his own insulin to hasten his death, dying with convulsions, dementia, violent outbreaks, and a total loss of dignity (App. 7);

- a daughter whose family had to clean her father's splattered brains off the basement walls after he shot himself with his 12-gauge shotgun to avoid the excruciating pain caused by lung cancer (App. 8);

- a daughter whose father lay dying, diapered, moaning in pain and begging to die while the

doctor refused morphine because it could kill him (App. 9);

- a widow devastated by watching her husband of 47 years live two months longer than he wished, slowly dying of cancer (App. 10);

- a man whose surrogate son failed in his suicide attempt and ended up in a coma (App. 11);

- a partner who was charged with murder and assisted suicide because he was present when his partner, dying of AIDS, took pills and sat in his car to ingest carbon monoxide (App. 12);

- a son who was criminally prosecuted for helping his 88 year old father, dying of cancer, hold a plastic bag over his head (App. 13);

- a man whose partner, dying of AIDS, destroyed his last few weeks of life agonizing about how to commit suicide (App. 14); and

- a daughter who had to leave her father to die alone so she would not be implicated in his death (App. 15).

The fifteen are among a significant number of Americans who have witnessed loved ones die in pain and agony, against their wishes and in an affront to their beliefs and personhood--denied the legal right to medical assistance to end unbearable suffering and hasten inevitable death.[4] They give

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[4]Various sources recount experiences of hundreds of Americans similar to the experiences of the fifteen representative family members. M. Battin, The Least Worst Death (1994); G. Burnell, Final Choices: To Live or to Die in an Age of Medical Technology (1993); C. Farnsworth, Vancouver AIDS Suicides Botched, N.Y. Times, June 14, 1994 at C12; S. Jamison, Final Acts of Love

their names and sacrifice their privacy and that of their family to preserve their liberty and the liberty of others who are terminally ill and wish to die with dignity. With the combined personal experiences of this group, the amicus has a profound interest in this litigation.[5]

II. SUMMARY OF ARGUMENT.

The amicus urges this Court to affirm the en banc decision of the Ninth Circuit Court of Appeals, Compassion in Dying v. State of Washington, 79 F.3d 790 (9th Cir. 1996), and the decision of the Second Circuit Court of Appeals, Quill v. Vacco, 80 F.3d 716 (2d Cir. 1996) finding unconstitutional Washington and New York statutes which make it a crime for a physician to knowingly aid another person in committing suicide as applied to the care of a competent, terminally ill patient.

(1995); G. Kolata, AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure, N.Y. Times, June 14, 1994 at C1; S. Nuland, How We Die: Reflections on Life's Final Chapter (1994); T. Quill, Death and Dignity: Making Choices and Taking Charge (1993); T. Quill, A Midwife Through the Dying Process (1996); J. Rachels, The End of Life (1986); B. Rollin, Last Wish (1985); L. Shavelson, A Chosen Death: The Dying Confront Assisted Suicide (1995); P. Singer, Rethinking Life and Death (1994); A. Solomon, A Death of One's Own, The New Yorker, May 22, 1995 at 54.

[5]Statements to the Court similar to those filed herein are not without precedent. In Webster v. Reproductive Health Services, 492 U.S. 490, 106 L. Ed. 2d 410, 109 S. Ct. 3040 (1989), an amicus brief filed with and considered by this Court, entitled "Women Who Have Had Abortions, et al.," included declarations by numerous women who had experienced legal and illegal abortions. As in Webster, the declarations filed here contain relevant first-hand information by persons intimately familiar with the issues on appeal. It should be noted that Petitioner State of Washington's Brief cites newspaper accounts of stories of people dealing with this issue. Washington Petitioner's Br. at 16-17.

The experience of one of the fifteen survivors--recounting the positive aspects of having a physician and other medical personnel assist in a hastened death--demonstrates why the choice to seek physician assistance is a liberty interest protected by the Due Process Clause of the Fourteenth Amendment. This one experience evidences the profoundly personal, intimate, and important nature of this decision, central to personal dignity and autonomy.

The experiences of the remaining fourteen survivors exemplify how the state laws prohibiting physicians from prescribing medication to hasten death burden the liberty interest of competent, dying patients. The Ninth Circuit decision below correctly recognized that the extent of the burden on liberty was one of several relevant factors in determining whether the challenged law violates an individual's substantive due process rights. Compassion in Dying, 79 F.3d at 816. The individual experience of each of the fourteen surviving family members presents one or more of the following ways in which the current laws constitute an undue burden:

- The current laws result in untold pain, agony, and suffering for some dying patients who would prefer death; a slow, debilitating death is often accompanied by a profound loss of dignity and self-respect.

- The current laws cause some patients to choose a violent, often gruesome manner of hastening death; these suicides are generally committed alone, without family present.

- The current laws result in the failure of some attempts to hasten death, due to the absence of trained medical care--sometimes leaving the patient in worse condition than before the attempt.

- The current laws result in some family members feeling compelled to assist their loved ones to hasten

death, with concomitant fear and hiding, guilt, and occasional criminal investigation and prosecution.

- The current laws result in suffering, guilt, anger, and remorse for some surviving family members.

Additionally, to deny medical assistance at a time of such need is to deny some terminally ill people equal protection of the law under the Fourteenth Amendment. To permit physicians to remove life support systems or to refrain from taking life sustaining measures, thereby hastening death, provides those terminally ill patients with a choice to die with dignity, a choice denied other terminally ill patients who cannot obtain medical assistance to hasten death.

III. THE CONSTITUTION PROTECTS INTIMATE, PERSONAL, AND IMPORTANT DECISIONS INCLUDING THE CHOICE OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR A TERMINALLY ILL, COMPETENT ADULT.

A competent, terminally ill patient has a liberty interest in determining the time and manner of his or her death. Planned Parenthood v. Casey, 505 U.S. 833, 851 (1992); Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261, 281 (1990). In Casey, this Court recognized that certain matters "involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment." Casey, 505 U.S. at 851. As the Ninth Circuit court below added:

> A competent terminally ill adult, having lived nearly the full measure of his life, has a strong liberty interest in choosing a dignified and humane death rather than being reduced at the end of his existence to a childlike state of helplessness, diapered, sedated, incontinent. How a person dies not only determines the nature of the final

> period of his existence, but in many cases, the enduring memories held by those who love him.

Compassion in Dying, 79 F.3d at 814.

For Richard Lau, the decision he made to choose physician assistance in dying during the last weeks of his life exemplifies the intimate, personal, and important nature of this decision.[6] For Roberta Lau, his widow, his decision positively affected the "enduring memory" she had of her husband's demise. Her statement reflects the dignity and peace that can accompany a physician-assisted death:[7]

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[6]Providing the means and ability to hasten death for the terminally ill can also provide a feeling of control over one's life and peace of mind, even if the physician prescribed medication is never used. Richard Posner, Age and Old Age 243-53 (1995). Moreover, having a physician involved in this important decision-making process can sometimes reverse a patient's decision to end his or her life. Under current state laws patients "... cannot make use of the professional help their doctors, psychologists, psychiatrists, or other counselors have to offer in exploring choices of suicide and which might provide them with very real help. As a result, some older, disabled, or dying persons commit suicide when they do not really wish to do so..." Margaret Pabst Battin, The Least Worst Death 272 (1994). "Our public policy should encourage doctors to be creative and openly responsive, rather than fearful and secretive, when patients are faced with a bad death." Timothy E. Quill, M.D., A Midwife Through the Dying Process 26 (1996).

[7]See Peter Singer, Rethinking Life and Death 148 (1994) for how a planned, hastened death in the Netherlands, where physician-assisted dying for the competent terminally ill is legal, can be even more dignified, since it is legal. The author describes the planned death of Carla: "She had the best possible medical attention, right up to the moment of death. Her family could be with her, and even her priest. Nothing had to be furtive. There was no need to fear failure. No-one had to lie awake afterwards wondering if the police would knock."

My husband of 42 years, Richard A. Lau, died on October 12, 1995. My husband's desire and intent always was to find the means to hasten his own death when his physical condition was no longer bearable. He died after taking a sufficient supply of drugs prescribed by a physician that took a long search and numerous inquiries to locate.
Richard had been battling lung cancer for two years before he died. ...

Approximately three weeks prior to Richard's death, he was examined by an independent physician, not his treating physician. This physician verified that Richard was mentally competent, not depressed, and fully aware of the consequence of his decisions. The physician determined that Richard's condition was terminal and that he had no more than one to two months to live. ...

Richard decided that he wished to die on Thursday, October 12, 1995. A nurse, my adult daughter, and two trained volunteers from Compassion in Dying were present with him. Everyone checked with Richard to see if he had changed his decision. He was clear and adamant in his determination to proceed.

Richard was helped with personal care matters, smoked a cigarette and visited with those present. He then personally took the medications. He was very relaxed and at peace and thankfully welcomed his liberation. He always worried so much about finding this assistance and it was a blessing when we did. We did not believe in prolonging suffering needlessly.

At the end, his death at home was very calm and peaceful. I supported him all the way.

I believe all terminal and suffering persons should be able to legally seek supervised and regulated assistance

in dying, if that is their wish. Prolonging suffering needlessly is inhumane.

Appendix 1.

IV. DENIAL OF THE CHOICE OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR COMPETENT, TERMINALLY ILL ADULT PATIENTS IMPERMISSIBLY INFRINGES UPON THE LIBERTY INTEREST OF THE PATIENTS.

State regulations may not impose an undue burden on recognized liberty interests. Casey, 505 U.S. at 873. The majority of the declarations show that the Washington and New York statutes, in prohibiting physicians from prescribing medication to end life, do impose an undue burden and thereby impermissibly infringe upon the liberty interests of competent, terminally ill patients.

A. Terminally Ill Patients Denied the Choice of Physician- Assisted Dying May Be Forced to Endure Horrific Pain and Suffering and Loss of Dignity.

All of the family members witnessed the intense suffering of their loved ones in the weeks or months before their inevitable deaths. The statements dispel the myth that pills can always control all pain.[8] Moreover, doctors sometimes refused to prescribe sufficient pain-killing medication because of their

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[8]Despite new advances in pain treatment, an "irreducible core of patients are trapped in physical agony (if they are awake)." Kreimer, 44 Am. U.L. Rev. at 831, n.93. Pain cannot be controlled in 5% to 10% of cases. The New York State Task Force on Life and the Law, When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context 40, n.18 (1994). Often, controlling pain sacrifices the patient's consciousness, which "is tantamount to causing death; the patient has no further conscious experience and thus can achieve no goods, experience no significant communication, satisfy no goals." M.P. Battin, supra, at 105.

fear that it would be used to hasten death.[9] Thus, laws barring physician-assisted dying contribute to suffering by causing some doctors to withhold medication. Additionally, as family members attest, a slow, deteriorating death often leads to loss of dignity and self-respect for the dying person.[10]

Dorothy Hoogstraat witnessed her husband's horrible suffering, which medication could not ease:

> My husband, Emerson E. Hoogstraat, a retired Professor of Finance, from Portland State University, died on March 25, 1995 of prostate cancer that had spread to the bones. . . .
>
> He was relatively comfortable until June of 1994 when a series of new problems developed. Following further diagnostic procedures it was ascertained that the cancer had spread to his ribs, spine and right femur. He was in considerable pain when walking, sitting or lying in bed. ... His ribs gradually broke, and as he said to me many times, he could feel the broken edges of the bones rub together as he would sit or attempt to arise from the bed. He was in unbearable pain. He was an extremely intelligent, courageous and dignified man and he did not wish to suffer unbearable pain when there was no hope of recovery from this condition. He would very much like to have gone to sleep in his own bed and not had to suffer further. He felt that it was his right to say when he had suffered enough. He "lived" at least two months after he would have preferred not to. The physicians and Hospice people were constantly changing medications and attempting to make him as comfortable as possible-- which in his condition was an

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[9]T. Quill, supra, at 197 ("Often, doctors undermedicate dying patients' pain or shortness of breath because of the legal risks [both exaggerated and real] associated with overmedicating.").

[10]See Sherwin B. Nuland, How We Die, Reflections on Life's Final Chapter 142 (1995).

> impossibility. It was a twenty-four hour a day caregiving situation and he still suffered unbearably. He remained at home until his death. ...
>
> We had been married for forty-seven years and shared a lifetime together, and truly, watching him suffer and being unable to do anything for him that would relieve his pain was for me devastating.
>
> I do not believe that God intended for people to suffer in this manner. We are more compassionate with our pets than we are with our dearly loved family members.
>
> Appendix 10.

Gail Bereny speaks of the unwillingness of her father's physician to prescribe adequate pain medication:

> Several years ago, my 80 year old father was diagnosed as having terminal abdominal cancer. He went to his doctor with two requests, (1) not to prolong things, and, (2) to keep him as pain free as possible. His doctor agreed. However when time came, the doctor did neither. And so my father, to whom dignity was very important, lay dying, diapered, moaning in pain, begging to die. I called the doctor's office, crying, begging him to relieve Dad's pain. He refused, saying morphine could kill him. . . .
>
> I felt very guilty then, and feel guilty now, about Dad's terrible death. I feel guilty that he died in so much pain and with no dignity left. The doctor had the means to give him a gentle, painless death. I have been left with frustration, anger, regret, and sadness. He had been a very good father.
>
> Appendix 9.

B. <u>Terminally Ill Patients Denied the Option of Physician-Assisted Dying Are Sometimes Forced to Experience a Violent, Lonely, at Times Gruesome Death</u>.

In a number of cases, the terminally ill chose violent deaths rather than continued suffering.[11] They died completely alone, without the comfort of their families. Their violent deaths often resulted in gruesome and tragic consequences for family left to deal with the remains.

Tania Bloom describes the brutal experience of her elderly father's suicide:

> In 1989, my father was dying of lung cancer and was in excruciating pain. His doctor would not provide pain medication other than Tylenol saying that to do so "would not be medically advisable." Father remained at home and in spite of being hooked up to oxygen, he struggled to breathe. We had access to morphine and hinted to him that we could get it for him if he wanted it. However, he refused because he knew it was illegal to assist in a suicide.
>
> When he realized that my family was going to be away for a day, he wrote us a beautiful letter, went down to his basement, and shot himself with his 12-gauge shotgun. He was 84. . . .
>
> This was a brutal and awful experience for my children and for me. I felt a great deal of loss, anger, and remorse about a system that would not allow my father to die gracefully and with dignity.

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[11]The Ninth Circuit court below cites the example of how one of the patients of physician plaintiff Dr. Harold Glucksberg ended his life by jumping from a bridge in Seattle after Dr. Glucksberg could not legally prescribe medication to hasten his patient's AIDS-related dying. <u>Compassion in Dying</u>, 79 F.3d at 834.

> My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.
>
> Physician assisted suicide should be a rational choice and a reassurance for people. Physician assisted suicide can have safeguards and planning so that it wouldn't be an impulsive, irrational act and one of unnecessary violence such as that of my Dad's.
>
> Appendix 6.

Patsy McGeorge's husband also felt compelled to end his life with a gun:

> My husband of twenty-five years, Emanuel J. ("Mac") McGeorge, had terminal cancer involving the spine, lungs and lymphatic system. But terminal cancer is cited only as "other significant condition" to his cause of death on the death certificate. The certificate reads: "Death due to or as a consequence of: Massive trauma to head -- self-inflected [sic] gun shot wound-shotgun." ...
>
> During late spring of 1995, he broached the subject of suicide. It was not the first time suicide had been mentioned, but this time he was quite serious. He told me of his great concern for becoming incapacitated, or so ill that he would either be hospitalized or would not, for some other reason, be able to govern his own destiny. He was relieved to have my assurance that he would never be hospitalized against his wishes, and that I would respect and support any decision he made about ending his own life. Mac also brought up the possibility of assisted suicide with his doctor, but while his doctor was understanding, he was not supportive.
>
> By October, Mac had already surpassed his predicted nine-month life expectancy, but the cancer was taking its toll. He had gone from a man of 190 pounds of muscle, exceptional strength, and superior stamina to a "145 pound weakling." ... By January of 1996, he was able to eat very little; his weight loss was becoming extreme. The principal spinal tumor had grown so large that he

referred to his appearance as that of the "Hunchback of Notre Dame." He could only sleep on his side, and despite 800 mg. of morphine a day and Roxicet every two hours, his pain was so extreme that sleep came only in short intervals. He could lie down for only an hour or two at a time. He struggled through January, but by the first of February, he couldn't take much more. We were referred to Hospice, an outstanding group that does a great deal to ease the pain and suffering of the terminally ill, but regrettably cannot assist in ending that suffering. With a subcutaneous pump to assure a continuous morphine flow and additional medication, Hospice nurses were able to provide Mac his first full night's sleep in months. But Mac did not want to be a drugged vegetable. Following an almost 24 hour drugged stupor, he decided that was not the answer.

On the morning of February 9, 1996, he had made up his mind. ... After a brief and very personal conversation, he gave me the note he had carried for months, attesting to the fact that his decision was his own; kissed me goodbye; went into the front yard, put a shotgun in his mouth and pulled the trigger. Since a peaceful death was not available, this was his way to insure death with the dignity he valued so highly. Two months ago I was emotionally wrenched by finding a portion of his upper dental plate 50 feet from the site of his death -- a testament to the violent alternative he was forced to choose.

Mac was not depressed -- the overwhelming pain or alternative of a drug stupor were simply unacceptable to him. Mac honestly believed he, with my support, had the right and the responsibility to control his own destiny.

To say that I miss him would be the understatement of the century. But I esteem his courage, his conviction, and his integrity. I am thankful that he loved me enough to share his most personal emotions. I wish I could have been with him at the end, but he said no, "it will be messy." Appendix 2.

Jinny Tesik attests to the loneliness involved when family members choose suicide, not wanting to legally implicate those left behind:

> Unable to live alone due to his own battle with emphysema, Dad lived with me for the last two years of his life. He was adamant that he would not let his disease control him the way his wife's lung cancer controlled her. He intended to take his life while he still had his dignity, self-respect, and, above all, was still in control of his life. He made me promise that I would honor his choice. He threatened that if the means for him to take control of his death were not available, he would kill himself with a kitchen knife.
>
> The emphysema progressed. Dad was tethered to 30 feet of oxygen tubing; he seldom left his bedroom. Breathing became more difficult and eating became a problem. His physician was totally opposed to providing the help Dad requested. One morning, he reminded me of my promise to help him. He discussed his plan rationally, non-emotionally. He was ready to die and needed my support. We raided the medicine cabinet and I was sent out to buy some vodka. We spent the day together. Toward evening, he asked me to leave the house and not return until very late. He did not want me to be implicated in any way in his suicide. Saying goodbye to my dad was one of the saddest times of my life. And I had to go through that long night alone for I, in turn, could not implicate anyone else in the knowledge of my dad's death. He died in 1990 at the age of 76.

Appendix 15.

C. Terminally Ill Patients Denied the Option of Physician-Assisted Dying May Be Forced to Rely on Family Members to Assist in Hastening Death.

Some of the fifteen deceased could or would not violently end their life with a bullet to the head. Nevertheless, they were determined to control the timing of their death and felt compelled to rely on the assistance of family.[12] This alternative brings other problems. The dying person has to worry about legal implications for survivors. Family members must engage in a conspiracy of silence to hide their involvement--at a time when they are grieving.[13] For some, criminal investigation and even prosecution for assisted suicide does result. Clearly, having untrained, emotionally involved family members assist in hastening death without medical supervision is not the most desirable alternative.[14]

Kay Beck, a retired school counselor, describes her involvement in her husband's death:

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[12]The Ninth Circuit court below recognized that an additional burden was that "[T]hose who decline to assist may always wonder whether they should have tried to save their parent or mate from enduring, unnecessary and protracted agony." Compassion in Dying, 79 F.3d at 836.

[13]Stephen Jamison, Ph.D., Final Acts of Love: Families, Friends, and Assisted Dying 169 (1995) ("Until the laws change, secrecy will remain one of the most dominant features of assisted death.").

[14]Ibid. 5 ("This illegal assistance ... goes on without guidelines, safeguards, psychological counseling or evaluations, required consultation with specialists, referrals to hospice, or even mandatory discussion of alternatives."). Moreover, sometimes family members are not those assisting. "In the absence of legally available aid from physicians, abuses are occurring at the hands of unregulated freelance euthanasists, illegal suppliers meeting an otherwise unmet demand." Lonny Shavelson, A Chosen Death: The Dying Confront Assisted Suicide 67 (1995).

> On Nov. 11, 1991, I helped my husband, Jack, end his life. In the terminal stages of esophogical [sic] cancer, he faced paralysis within days. Paralysis for Jack was a fate worse than death. Always an extremely active, rational, self reliant, responsible person, he fought for his life as long as he could. When it became apparent the end was near our plan was that he would end his life with sleeping pills, as difficult and isolating as that proved to be. On the 10th of November he wrote his suicide note and we prepared the drugs. Jack died the next morning of a drug overdose in the room he loved with me but not our children by his side.
>
> The effect of the law against assisted suicide is to create a conspiracy of silence around the terminally ill at their time of ultimate loss and greatest need. It causes isolation, anguish, desperate acts, and prolonged suffering. I do not wish to go to jail but who is to speak for those who have died alone or those who fear prosecution if I do not.
>
> To classify me as a criminal because I refused to leave my husband's side at his time of greatest loss I find unconscionable. The law against assisted suicide is a travesty, a violation of my rights as an adult. The judicial system must find this law unconstitutional or be prepared to put people like me in jail.
>
> Appendix 4.

Patty Rosen had the unthinkable task of helping her daughter hasten her death:

> The person dying was my 25 year old daughter and she asked me to help her die, and I did. I didn't have to assist Jody's death. Jody was still capable of giving herself a fatal dose of medication. But Jody didn't want to die alone. She wanted me there with her, to comfort her, and to make sure she died.
>
> Bone cancer. Invasive bone cancer. Literally, from her head to her toes she was filled with bone cancer. ... Bedridden, Jody was trapped in a body that barely

worked. She slept, medicated, 23 out of 24 hours. Even then her face reflected the pain she was constantly enduring. She was also losing her sight, tolerated painful procedures for total bowel obstruction, and shuddered with pain if anyone so much as touched her skin because of the tumors that were barely under the surface. And, her bones. Bones that were slowly "burning" ("it feels like hot molten lava inside of me") away with cancer. Daily she let me feel her despair. Daily, her eyes dulled by medication, the question would come: "Mom, how long can you watch me suffer?" "Mom, please help me." ...

... She was dying, she knew it, and she was ready to die now. Rational, calm, ready. However, it was illegal for me to assist and she knew it. "I should be able to talk with my doctor and plan this, not ask my Mom" "Mom, what if you go to prison?" "What will happen to you?" Worry made her small face with the sunken eyes of the near death take on an incredibly distressed look. Wasn't it enough that she was dying without having to worry about me? ...

Finally, four months after her request, choking on my tears, I said, "Jody, I'm ready." A look of relief came over her face. She was, in fact, almost giddy with relief. Quietly, softly she said, "Oh Mom, thank you. This is one of the happiest days for me. I don't have to wake up in this body again." ...

And then it was time. Jody calmly swallowed everything I could give her, took a few sips of water, kissed me, "See you later Mom," closed her eyes and went to sleep. I went into a pure panic. What if I failed? What if she regained consciousness? She would be even worse off. But more than that, I would have failed her. I began giving her all the I.V. medications I could pump into her stilled body. I moaned, sobbed, prayed, and kept pushing the drugs. I was as desperate as I have ever been. ...

Ten hours after we had started the process came the silence. She had finally stopped breathing. The year

and a half of pain, suffering, rage, and hopelessness had ended. I climbed into her bed, gathered her still body into my arms, finally able to hold her without hurting her. Stroking her hair, rocking her gently, I surrendered to my grief. A brave and wise young woman, Jody Lynn Grape, age 26, died October 30th, 1986, at 1:30 p.m.

I have never felt guilt or remorse for assisting Jody's passing. It was the ultimate act of love a mother could do for her suffering, dying child. I am grateful she trusted me enough to ask, made me feel her anguish, and included me in her dying. ...

Appendix 6.

Elvin Sinnard describes his wife's death and her worry about Elvin's involvement, even as she was on the brink of death:

Sara and I were married for 49 years. She suffered from a very painful heart condition the last eleven years of her life. Two open heart surgeries, several trips across the United States to specialty clinics, and very competent care from her cardiologist failed to relieve the debilitating pain. Finally life became unbearable. She could not even talk to me, her children, or her friends for five minutes without triggering the terrible pain. She wanted to die but we did not know how to do it. We could not ask her doctors since one practiced in a Catholic hospital and the other had a national reputation that would have been destroyed had he broken the law to help her.

She feared over-the-counter pills, hearing of all the cases where the person woke up a vegetable. Carbon monoxide was out since she wanted the dignity of dying in her own bed, surrounded by the things she loved. We finally learned of the plastic bag method. On the day of her decision, I was with her up to the point of placing the bag over her head and she said, "Elvin, you must

now go to the office because you cannot be implicated in this."

She had to die alone. I was denied my right to be with her when she died. This is not right.

I was taken to the police headquarters and interrogated for two hours attempting to establish a direct action on my part to the suicide. The detectives were polite and seemed sympathetic but they said, "Even though we might agree with your action, we would have to recommend indictment if we could establish a direct action on your part to the suicide. It's the law."

And, this is not right. My act was a loving act, not a criminal act.

A person has the right to control the conditions of their death as much as they have the right to control the conditions of their living.

Appendix 2.

William Meyer details his prosecution for helping his 88 year old father end his life:

In 1991, my father, William F. Meyer Jr., who was 88 years old and had experienced five cancer operations, was in rapidly failing health. The cancer that had begun in his colon had spread to his lungs. He was losing weight and was being eaten away. His doctor said he only had a few months to live. ...

After my father and I met with my father's doctor of 25 years, my father decided he would use the procedure featured in the book Final Exit, taking 12 sleeping pills and placing a plastic bag over his head.

My father's first attempt at this action failed when his reflex action, which comes from the feeling of suffocating, caused him to pull off the plastic bag. When I returned to my father's home the next morning, he was awake and distressed that he was still alive.

My father consulted with his doctor and was advised that I could hold my father's hands so the reflex action

would not remove the plastic bag. My father and I followed this procedure and he was able to end his life.

Since one of my father's last requests was that I tell his story, I joined the Hemlock Society and became a vocal spokesman for death with dignity. In the summer of 1994, I was interviewed for a story by Connecticut Magazine. After the story, I was arrested and charged by the police with second degree manslaughter. If convicted, I faced ten years in prison.

At a hearing in December, 1994, before a Superior Court judge in Hartford, Connecticut, two ministers and several friends spoke on my behalf. Numerous people, including eleven ministers and eighteen doctors, wrote to the judge to support me. Even though the District Attorney pleaded that my case go to trial, the judge stated that although I had broken the law, I was following my father's wishes, and the judge considered me an outstanding citizen. I was given two years "accelerated rehabilitation" (after two years, all charges are dropped, with no record)....

Appendix 13.

Keith Green describes the horror of being charged with murder and assisted suicide after his long term partner died:

I was arrested on December 4, 1995 in West Los Angeles after my lover of eight years committed suicide. Within hours of the arrest, I was charged with murder under California Penal Code section 187 and felony assisted suicide under California Penal Code section 401.

...

In 1991, my lover tested positive for the human immunodeficiency virus ("HIV") and was diagnosed with full blown AIDS in early 1994. He was in the advanced final stages of the disease at the time of his demise. With his immune system entirely compromised he suffered from a panoply of debilitating diseases which were incurable....

On Monday, December 4, 1995, he told me that this would be our last morning together. He went into the bathroom where he remained for a considerable period of time. I learned afterwards that he had been taking a large and lethal quantity of chlorohydrate [sic] and seconal. Because his prior attempt at suicide by pills had failed, he had planned to use carbon monoxide as a back up.

After a tearful goodbye, he went to the garage where he had set up his car with tubing so as to facilitate the ingestion of carbon monoxide. Once seated in the driver's side of his car, he told me that it was time for me to leave....

I returned to our home within five to ten minutes of leaving. I went to the garage which was then filled with smoke and stayed with him in the car ...

After having been prosecuted for a felony for six months, the charges were finally dismissed on June 4, 1996. Though released on my own recognizance within a few days of having been arrested, the terms and conditions of my release precluded me from being at his funeral in his home town of Longview, Texas as I was not allowed to leave California....

In the end, the charges that were filed against me were the last thing that he would have ever wanted to happen.

Appendix 12.

D. <u>Terminally Ill Patients Denied the Option of Physician-Assisted Dying Sometimes Fail in Their Attempts to Hasten Death, with Tragic Results</u>.

Perhaps the worst result for a terminally ill competent adult who attempts suicide--worse than a violent suicide, or a lonely suicide, or a suicide implicating family members--is a suicide that fails, leaving the patient worse off than before. The denial of medical assistance inevitably increases the chance of a botched hastened death. Patients cannot know the type or dosage of medication to take or how to control nausea and

regurgitation accompanying the ingestion of lethal medication.[15] As the Ninth Circuit decision stated, "Miscalculation can be tragic."[16] The consequence can be brain damage or a coma.[17]

For Gösta Pearson, his surrogate son, dying of AIDS, failed in his attempt to hasten death which brought tragic consequences.

> On June 20, 1991, Hugo told me that he had decided to take his own life with some pills he had stockpiled. He told me I did not have to stay with him, but I wanted to be by his side. He prepared two glasses of

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[15]L. Shavelson, <u>supra</u>, at 126 ("From safer sleeping pills to air bags in cars, science has made killing yourself without professional help a tremendously difficult task--and a mission fraught with the potential for ghastly errors.")

[16]<u>Compassion in Dying</u>, 79 F.3d at 832. Additionally, the Second Circuit quoted from one of the declarants in that case, <u>Quill v. Vacco</u>, 80 F.3d at 721:

> It is not uncommon, in light of present legal constraints on physician assistance, that patients seeking to hasten their deaths try to do so without medical advice.... Very often, patients who survive a failed suicide attempt find themselves in worse condition than before the attempt. Brain damage, for example, is one result of failed suicide attempts.

[17]<u>See</u> C. Farnsworth, <u>Vancouver AIDS Suicides Botched</u>, N.Y. Times, June 14, 1994, at C12 (of 34 assisted suicides studied in Vancouver, B.C. [which, similar to the U.S., bans physician assisted suicide], half were "botched, increasing suffering when the aim was to alleviate it."); Andrew Solomon, <u>A Death of One's Own</u>, The New Yorker, May 22, 1995, at 57 ("I heard of suicides as gruelling as the diseases they were meant to terminate. In some cases, irreplaceable pills were regurgitated. "My husband had to just eat his vomit," one woman said. "He was that determined. But then he threw up again. We waited about an hour; then he downed it all again and I put a plastic bag over his head so he would suffocate before he got sick, and he finally died. He'd been through so much, and that whole disgusting, humiliating business was the living end.").

medication and told me he was going to drink one glass and then follow with the other. He then drank all of one of the glasses. He then told me that "that didn't taste very good--will you get me a spoon of pudding from the kitchen". I did and he said "that's better." Then he reached for the second glass and passed out before taking the second glass of medication.

Hugo was in a coma for the next several days. I immediately called his physician, who came and examined him. Hugo remained in his home, receiving no food or hydration. Medical personnel told me that Hugo could hear us, even though he was not responding to us.

This was the worst seven days of my life. It was miserable for me, for Hugo, and for others to see his desired death stretched out for so long. I slept in his apartment during that week in order to be close to him.

If Hugo had been able to have a physician assist him in his dying, he could have died when and how he wanted, with dignity and without further complications and problems.

A program should be able to be developed so that people don't make the same bungling mistakes Hugo did. It is important for people in Hugo's situation to have the freedom of choice to end their life, without fear and without complications which make their dying process a nightmare.

Appendix 11.

V. DENIAL OF THE OPTION OF PHYSICIAN ASSISTANCE TO HASTEN DEATH FOR COMPETENT, TERMINALLY ILL PATIENTS HAS DEVASTATING CONSEQUENCES FOR SURVIVING FAMILY MEMBERS.

The states and other amici assert an interest in protecting from suicide the family members and loved ones of the

terminally ill.[18] However, as the Ninth Circuit court below observed, ". . . witnessing a loved one suffer a slow and agonizing death as a result of state compulsion is more likely to harm than further the interests of the innocent third parties." Compassion in Dying, 79 F.3d at 827.

The family members express extreme sadness, anger, and guilt over their loved ones' loss of dignity and loss of control over their own lives, resulting from laws prohibiting physician assistance in dying. Others decry a cruel legal system which legislates against the abstract notion of "suicide" rather than addressing the reality of the pain, suffering, and loss of personal autonomy and dignity of terminally ill, competent patients. This law leaves family members angry and frustrated that they are unable to obtain comfort for the loved one at his or her time of greatest need.

> I felt very guilty then, and feel guilty now, about dad's terrible death. I feel guilty that he died in so much pain and with no dignity left. The doctor had the means to give him a gentle, painless death. I have been left with frustration, anger, regret, and sadness....
>
> Declaration of Gail Bereny (App. 9).

> It was a very lonely death. That's the one thing I will never get over. My mother came from out-of-state to be with me for a period of time as she was concerned for my emotional health. I was in therapy for six months.
>
> Declaration of Steve Knipp (App. 14).

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[18] See Compassion in Dying, 79 F.3d at 816, for discussion of State of Washington's arguments in this regard; also, see Amicus Curiae Brief of Nat'l Right to Life Committee, Inc., p. 26, which argues that children "may be more profoundly affected by suicide than by other cases leading to the death of a parent." This is undoubtedly true for ordinary suicides, but the statement hardly applies to suffering parents at the end of their lives.

> My mother's terminal illness was awful for me because I was very close to her. I had nightmares for weeks prior to her death. She was desperate, and in spite of my being a nurse, I felt helpless....
>
> Declaration of Leanne Gallison (App. 3).

The Ninth Circuit decision voiced "serious doubts that the terms 'suicide' and 'assisted suicide' are appropriate legal descriptions of the specific conduct at issue here." Compassion in Dying, 79 F.3d at 802. For this reason, we frequently use in this brief the term "physician-assisted dying" or "hastened death" rather than "suicide." Jinny Tesik, who supported the controlled dying of her 76-year-old father, suffering from terminal emphysema, compares her father's act with other suicides:

> My 39 year old husband committed suicide violently ten years ago by shooting himself in the head. That is the kind of suicide that leaves the legacy of guilt, anger, and unanswered questions. That kind of suicide devastates and destroys those left behind.
>
> After 12 years of working in hospice and as a grief counselor, I have heard far too many cases of others like my father who chose to be in control of their deaths. For those who choose their own death in their own time, let it be peaceful, loving and legal, not shattered by violence and shame.
>
> Appendix 15.

VI. THERE IS NO MEANINGFUL DISTINCTION FOR THE PATIENTS AND SURVIVING FAMILY MEMBERS BETWEEN A PHYSICIAN'S ASSISTANCE IN HASTENING DEATH AND A PHYSICIAN'S WITHDRAWAL OF LIFE SUPPORT.

A. The Deceased Loved Ones of the Amicus Were Dying of Terminal Illnesses and Suffering in the Same Way that Terminally Ill People with Life Support Measures Suffer.

The experiences of the amicus demonstrate that the distinction in the laws between withdrawing or refusing life support measures, a form of medical intervention, and choosing other forms of physician assistance to hasten the death of a terminally ill patient is meaningless for both the patient and the family. The patients who seek physician assistance to prescribe medication and those who seek physician assistance for withdrawal of life-sustaining treatment to hasten death are similarly situated. In both cases, the patients are facing an inevitable death caused by a fatal disease and are suffering, often unbearably.

The patients described by the fifteen declarants all suffered from diseases for which "life support," such as a ventilator or respirator, was not at issue. But they suffered as much as patients on life support, they knew they were dying, and they had exhausted all efforts to save themselves. Like those patients who make the choice to accept and hasten their inevitable deaths by refusing or withdrawing life support, they too wanted to end their suffering. Because of state statutes, they were denied the option to end their suffering with dignity and the comfort of their families.

B. <u>The Legislatures' Distinctions Between the Refusal or Withdrawal of Life Support to Hasten Death and the Acceptance of Other Forms of Physicians' Assistance to Hasten Death is Not Rational</u>.

The distinction in the law between withdrawal of life support and physician-assisted suicide makes no sense to those who are suffering while dying or to the families and loved ones who watch them suffer. It is not legally sufficient to say that because the state legislatures treat these actions as different, that they are in fact different. The Second Circuit accurately concluded that the withdrawal or refusal of life support <u>is</u> a form of assisted hastening of death and the two classes of patients should be treated equally. The Court explained:

> Withdrawal of life support requires physicians or those acting at their direction physically to remove equipment and, often, to administer palliative drugs which may themselves contribute to death. The ending of life by these means is nothing more nor less than assisted suicide. It simply cannot be said that those mentally competent, terminally-ill persons who seek to hasten death but whose treatment does not include life support are treated equally.

<u>Quill v. Vacco</u>, 80 F.3d at 729.

The irrational nature of the distinction between the two classes of people is demonstrated by the drastic actions patients sometimes take to "legally" end their suffering. Jeff Halsey explains his partner Danial Danzer's struggle with AIDS:

> My partner Danial Danzer's biggest fear was that of losing his mind. He wanted to die before he lost his mind.
>
> Danial had reached the final stages of AIDS. He sought help with his problems from the medical community but didn't receive any. So when he felt his mind was leaving him, he opted for a unique solution to his problem, that being withholding his insulin and letting himself die of insulin stock. It was a very long five days of convulsions, dementia, violent outbreaks, and a total loss of self-dignity.
>
> I feel that had there been a way for him to end his life peacefully, that he would have opted to do so. Danial was lucky in that he had a way to deliver himself--by withholding his insulin. Most people are not that lucky. Most people must suffer even more than Danial suffered.

Appendix 7.

It is ironic that Danzer could legally withhold medication, such as insulin, but could not legally have a more painless way to hasten his death and maintain his dignity. Under Petitioners' rationale, Danzer's death was not legally "suicide" because the death was "unintentional," "inactive," and "natural," since Danzer died from diabetes and insulin shock. Washington Petitioners' Br. at 31 and New York Petitioners' Br. at 15-19. Clearly, Danzer's death was intended and he very actively sought death. How "natural" is it to die of convulsions and dementia? Similarly, how "natural" is death by starvation and dehydration, or an induced coma, both legal in Washington and New York states? The Second Circuit concluded these deaths are no more "natural" than a doctor prescribing medication to hasten death. <u>Quill</u>, 80 F.3d at 729.

VII. CONCLUSION

As the experiences of the fifteen show, many people are determined to control the dying process when faced with a debilitating terminal illness. This Court cannot stop the terminally ill from hastening their deaths--it does happen and will continue to happen as long as human beings have free

will.[19] The decision for this Court is how hastened dying for the adult terminally ill should occur: Will it be acts of violence taken alone? Will it be untrained family members compelled to assist in secrecy and fear? Or will it be medically-trained personnel evaluating and assisting, in the open, according to legal guidelines? Amicus urges the Court to recognize, as the Second and en banc Ninth Circuit Courts did, that legal guidelines can be established so that the state can protect its legitimate interests without substantially infringing upon the constitutional rights of those competent, terminally ill adults who choose to end their suffering and hasten death.

Respectfully submitted,

KATRIN E. FRANK
*ROBERT A. FREE
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Attorneys for Amicus Curiae Surviving Family Members in Support of Physician-Assisted Dying

*Counsel of Record

December 5, 1996.

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[19]T. Quill, supra, at 199 ("Doctors, patients, and their families are engaged in negotiated deaths every day in every community in the United States."). With AIDS, the number of end-of-life suicides has increased dramatically. G. Kolata, AIDS Patients Seek Solace in Suicide But Many Risk Added Pain in Failure, N.Y. Times, June 14, 1994, at C1.

PERSONAL DECLARATION OF ROBERTA LAU

My name is Roberta Lau. My address is 9586 Silver Creek Lane NW, Bremerton, Washington 98311. My date of birth is October 31, 1928.

I prepare this declaration to support the position of Compassion in Dying in the case of Compassion in Dying vs. State of Washington.

My husband of 42 years, Richard A. Lau, died on October 12, 1995. My husband's desire and intent always was to find the means to hasten his own death when his physical condition was no longer bearable. He died after taking a sufficient supply of drugs prescribed by a physician that took a long search and numerous inquiries to locate.

Richard had been battling lung cancer for two years before he died. The cancer had metastasized from his lungs to his thigh bone, hip, arm, neck and head. His body had become a skeleton and his pain and suffering were worse. He decided it was time to fulfill his wish of assistance in dying. I was always aware of this intention and in total agreement and understanding.

Approximately three weeks prior to Richard's death, he was examined by an independent physician, not his treating physician. This physician verified that Richard was mentally competent, not depressed, and fully aware of the consequence of his decisions. The physician determined that Richard's condition was terminal and that he had no more than one to two months to live. He verified that Richard had lost 62 pounds in the last 15 months and had documented metastases.

Richard decided that he wished to die on Thursday, October 12, 1995. A nurse, my adult daughter, and two trained volunteers from Compassion in Dying were present with him. Everyone checked with Richard to see if he had

changed his decision. He was clear and adamant in his determination to proceed.

Richard was helped with personal care matters, smoked a cigarette and visited with those present. He then personally took the medications. He was very relaxed and at peace and thankfully welcomed his liberation. He always worried so much about finding this assistance and it was a blessing when we did. We did not believe in prolonging suffering needlessly.

At the end, his death at home was very calm and peaceful. I supported him all the way.

I believe all terminal and suffering persons should be able to legally seek supervised and regulated assistance in dying, if that is their wish. Prolonging suffering needlessly is inhumane.

I hereby declare under penalty of perjury under the laws of the State of Washington and of the United States that the above statement is true and correct.

Dated: November 13, 1996

Place of execution: Bremerton, Washington.

/s/
Roberta Lau

PERSONAL DECLARATION OF
PATSY McLAUGHLIN McGEORGE

My name is Patsy M. McGeorge (a.k.a. Patsy A. McLaughlin, Ph.D.). My address is 1760 Parson Creek Road, Sedro Woolley, WA 98284-9620. My date of birth is May 27, 1932.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My husband of twenty-five years, Emanuel J. ("Mac") McGeorge, had terminal cancer involving the spine, lungs and lymphatic system. But terminal cancer is cited only as "other significant condition" to his cause of death on the death certificate. The certificate reads: "Death due to or as a consequence of: Massive trauma to head -- self-inflected (sic) gun shot wound-shotgun."

Mac was diagnosed with cancer in November of 1994. Because he was 72 years of age, he rejected massive chemotherapy and radiation and asked just for drugs to ease his then acute pain. For a man who rarely took even aspirin, the nausea, dizziness, and other side effects of simply increasingly higher levels of pain medication served to reaffirm for him the soundness of his decision.

During late spring of 1995, he broached the subject of suicide. It was not the first time suicide had been mentioned, but this time he was quite serious. He told me of his great concern for becoming incapacitated, or so ill that he would either be hospitalized or would not, for some other reason, be able to govern his own destiny. He was relieved to have my assurance that he would never be hospitalized against his wishes, and that I would respect and support any decision he made about ending his own life. Mac also brought up the possibility of assisted suicide with his doctor, but while his doctor was understanding, he was not supportive.

By October, Mac had already surpassed his predicted nine-month life expectancy, but the cancer was taking its toll. He had gone from a man of 190 pounds of muscle, exceptional strength, and superior stamina to a "145 pound weakling." What stamina remained came from sheer will power and intestinal fortitude, yet he managed to put his shop in order, teach me his special techniques in the darkroom and continue his daily routines. By January of 1996, he was able to eat very little; his weight loss was becoming extreme. The principal spinal tumor had grown so large that he referred to his appearance as that of the "Hunchback of Notre Dame." He could only sleep on his side, and despite 800 mg. of morphine a day and Roxicet every two hours, his pain was so extreme that sleep came only in short intervals. He could lie down for only an hour or two at a time. He struggled through January, but by the first of February, he couldn't take much more. We were referred to Hospice, an outstanding group that does a great deal to ease the pain and suffering of the terminally ill, but regrettably cannot assist in ending that suffering. With a subcutaneous pump to assure a continuous morphine flow and additional medication, Hospice nurses were able to provide Mac his first full night's sleep in months. But Mac did not want to be a drugged vegetable. Following an almost 24 hour drugged stupor, he decided that was not the answer.

On the morning of February 9, 1996, he had made up his mind. He said he felt as if he had just been through Ray Milan's "Lost Weekend," and told me that with such a high level of pain medication he would soon be a vegetable, unable to think, do for himself, or control his own destiny -- an intolerable situation. After a brief and very personal conversation, he gave me the note he had carried for months, attesting to the fact that his decision was his own; kissed me goodbye; went into the front yard; put a shotgun in his mouth and pulled the trigger. Since a peaceful death was not available, this was his way to insure death with the dignity he valued so highly. Two months ago I was emotionally wrenched by finding a portion of his upper dental plate 50 feet from the site of his death -- a testament to the violent alternative he was forced to choose.

Mac was not depressed -- the overwhelming pain or alternative of a drug stupor were simply unacceptable to him. Mac honestly believed he, with my support, had the right and the responsibility to control his own destiny.

To say that I miss him would be the understatement of the century. But I esteem his courage, his conviction, and his integrity. I am thankful that he loved me enough to share his most personal emotions. I wish I could have been with him at the end, but he said no, "it will be messy."

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above mentioned is true and correct.

Signed: /s/

Dated: September 27, 1996

Place of execution: Sedro Woolley, WA

PERSONAL DECLARATION OF
LEANNE GALLISON

My name is Leanne Gallison. My address is 7538 - 14th Ave. N.E., Seattle, Washington 98115. My date of birth is February 2, 1952.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My mother, B.J. Olsen, was diagnosed with cancer in August, 1993 at the age of 69. She was given six months to two years to live. In September she started chemotherapy which helped a little. Later, additional chemotherapy didn't help. Sharp pains developed in her chest and her spine. Shortness of breath increased. Chemotherapy made her horribly ill, nauseated around the clock. The doctor ordered radiation therapy to ease the pain. At this time, she began to have seizures. Tumors were discovered in her brain. Radiation was added to treat her brain but this resulted in my mother becoming completely flattened with no stamina, no energy. The doctor predicted that within a month or so, she would begin to feel better, she would regain her strength, and perhaps she and her family could go on a vacation. She never got better. She couldn't even get out of the house.

My mother had been a single woman for 30 years. She was left fatherless when she was 2 and abandoned by her husband when her children were still in school. She built her own successful business, traveled in Africa and the Middle East, and put us all through graduate school. She even volunteered many hours each week at a clinic for disabled children. She was petite, beautiful, and determined. She was not about to give up control over her destiny.

As the pain and sleeplessness increased, and in her housebound state, she began to think about how she could end her life with grace and dignity. The last thing she wanted was to be completely dependent on her family. She asked her doctor for

some barbiturates to "help her sleep." When he realized why she wanted them, he flatly refused. She was terribly discouraged. She had to change doctors to seek help. On her bad days she would ask me, "How am I going to get out of here?" And, "I want to go, and I want to go NOW!" She weighed about 60 pounds. One evening, with her children by her side, she consumed some antinausea medication in mashed fruit, and later swallowed all of the morphine she had left. She fell peacefully asleep. She stopped breathing in two hours.

My mother's terminal illness was awful for me because I was very close to her. I had nightmares for weeks prior to her death. She was desperate, and in spite of my being a nurse, I felt helpless. I just don't see how an assisted suicide is dangerous if it is regulated. It is like a Living Will; I just don't see anything wrong in it.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Date: July 29, 1994
Place of execution: Seattle, Washington
Signature: _____/s/_____
Leanne Gallison

PERSONAL DECLARATION OF KAY BECK

My name is Kay Beck. My address is 5024 Nicklas Place N.E., Seattle, Wa. 98105. My date of birth is Jan. 18, 1936.

I prepared this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

On Nov. 11, 1991, I helped my husband, Jack, end his life. In the terminal stages of esophogical cancer, he faced paralysis within days. Paralysis for Jack was a fate worse than death. Always an extremely active, rational, self reliant, responsible person, he fought for his life as long as he could. When it became apparent the end was near our plan was that he would end his life with sleeping pills, as difficult and isolating as that proved to be. On the 10th of November he wrote his suicide note and we prepared the drugs. Jack died the next morning of a drug overdose in the room he loved with me but not our children by his side.

The effect of the law against assisted suicide is to create a conspiracy of silence around the terminally ill at their time of ultimate loss and greatest need. It causes isolation, anguish, desperate acts, and prolonged suffering. I do not wish to go to jail but who is to speak for those who have died alone or those who fear prosecution if I do not.

To classify me as a criminal because I refused to leave my husband's side at his time of greatest loss I find unconscionable. The law against assisted suicide is a travesty, a violation of my rights as an adult. The judicial system must find this law unconstitutional or be prepared to put people like me in jail.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 2, 1994
Place of execution: Seattle, Washington
_____/s/_____

PERSONAL DECLARATION OF
ELVIN O. SINNARD

My name is Elvin O. Sinnard. My address is 23 Beckett, Lake Oswego, Oregon 97035. My date of birth is May 30, 1917.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

Sara and I were married for 49 years. She suffered from a very painful heart condition the last eleven years of her life. Two open heart surgeries, several trips across the United States to specialty clinics, and very competent care from her cardiologist failed to relieve the debilitating pain. Finally life became unbearable. She could not even talk to me, her children, or her friends for five minutes without triggering the terrible pain. She wanted to die but we did not know how to do it. We could not ask her doctors since one practiced in a Catholic hospital and the other had a national reputation that would have been destroyed had he broken the law to help her.

She feared over-the counter pills, hearing of all the cases where the person woke up a vegetable. Carbon monoxide was out since she wanted the dignity of dying in her own bed, surrounded by the things she loved. We finally learned of the plastic bag method. On the day of her decision, I was with her up to the point of placing the bag over her head and she said, "Elvin, you must now go to the office because you cannot be implicated in this."

She had to die alone. I was denied my right to be with her when she died. This is not right.

I was taken to the police headquarters and interrogated for two hours attempting to establish a direct action on my part to the suicide. The detectives were polite and seemed sympathetic but they said, "Even though we might agree with your action, we would have to recommend indictment if we could establish a direct action on your part to the suicide. It's the law."

And, this is not right. My act was a loving act, not a criminal act.

A person has the right to control the conditions of their death as much as they have the right to control the conditions of their living.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 2, 1994

Place of execution: Portland, Oregon 97035

/s/
Elvin O. Sinnard

PERSONAL DECLARATION OF PATTY ROSEN

My name is Patty Rosen. My address is 60734 Bristol Way, Bend, OR 97702.

I prepare this Declaration to support the position of Compassion in Dying in the case of Compassion in Dying v. State of Washington.

For as long as I can remember I have believed that any person suffering from a terminal or debilitating illness has the right to end their life when they choose. My religious and moral beliefs have never interfered with my ability to listen and empathize as patients have pleaded their case to die. I have even made pacts with friends who feel as I do, agreeing that if the need should ever arise, we will help each other die. I have also talked with my four children about the right to choose, encouraging them to think about it, discuss it, and come to their own conclusions. Then, in one short year the subject of assisting the death of a terminally ill person was no longer clinical and abstract. The person dying was my 25 year old daughter and she asked me to help her die, and I did. I didn't have to assist Jody's death. Jody was still capable of giving herself a fatal dose of medication. But Jody didn't want to die alone. She wanted me there with her, to comfort her, and to make sure she died.

Bone cancer. Invasive bone cancer. Literally, from her head to her toes she was filled with bone cancer. The failure to do follow-up on an obvious, thyroid goiter, first diagnosed when she was 18, had led her, over a five year span, to death's door. Jody was devastated. Angry that she was dying, and furious that it could have been prevented, she asked me to keep her at home and care for her. She was also afraid that if hospitalized she would lose her autonomy. She had been trained as a nurse's aid and had witnessed, first hand, how the rights of patients were violated and didn't want that to happen to her. I was greatly relieved she trusted me so completely because I was frantic to take her in my arms and somehow "make it better." But that never happened. Bedridden, Jody was trapped in a body that barely worked. She slept, medicated, 23 out of 24 hours. Even then her face reflected the

pain she was constantly enduring. She was also losing her sight, tolerated painful procedures for total bowel obstruction, and shuddered with pain if anyone so much as touched her skin because of the tumors that were barely under the surface. And, her bones. Bones that were slowly "burning" ("it feels like hot molten lava inside of me") away with cancer. Daily she let me feel her despair. Daily, her eyes dulled by medication, the question would come: "Mom, how long can you watch me suffer?" "Mom, please help me."

What could I say? Was I going to tell her she would get better? That this was temporary? What reason could I give her not to die when she was already dying? She was dying, she knew it, and she was ready to die now. Rational, calm, ready. However, it was illegal for me to assist and she knew it. "I should be able to talk with my doctor and plan this, not ask my Mom" "Mom, what if you go to prison?" "What will happen to you?" Worry made her small face with the sunken eyes of the near death take on an incredibly distressed look. Wasn't it enough that she was dying without having to worry about me? In my most convincing style I reassured her. Her trust and faith in me were humbling and I was determined not to let her continue to suffer because of what might happen to me. I found the idea absurd.

Finally, four months after her request, choking on my tears, I said, "Jody, I'm ready." A look of relief came over her face. She was, in fact, almost giddy with relief. Quietly, softly she said, "Oh Mom, thank you. This is one of the happiest days for me. I don't have to wake up in this body again." Those words, to this day, make me sob with my own pain of loss. I miss her so much.

And then it was time. Jody calmly swallowed everything I could give her, took a few sips of water, kissed me, "See you later Mom," closed her eyes and went to sleep. I went into a pure panic. What if I failed? What if she regained consciousness? She would be even worse off. But more than that, I would have failed her. I began giving her all the I.V. medications I could pump into her stilled body. I moaned, sobbed, prayed, and kept pushing the drugs. I was as desperate as I have ever been. My mind started playing tricks on me. Looking at her I would suddenly think I had

made a mistake, that she was not terminally ill, but was getting better. I fought the impulse to reach for her, to shake her awake, or to pick up the phone and call for help. I forced myself to stay in the naked reality of the situation, to look at my daughter's withered frame, her cadaver-like skull, and to continue my vigil.

Ten hours after we had started the process came the silence. She had finally stopped breathing. The year and a half of pain, suffering, rage, and hopelessness had ended. I climbed into her bed, gathered her still body into my arms, finally able to hold her without hurting her. Stroking her hair, rocking her gently, I surrender to my grief. A brave and wise young woman, Jody Lynn Grape, age 26, died October 30th, 1986, at 1:30 p.m.

I have never felt guilt or remorse for assisting Jody's passing. It was the ultimate act of love a mother could do for her suffering, dying, child. I am grateful that she trusted me enough to ask, made me feel her anguish, and included me in her dying. Her request was a rational request. She made her decision independently, following her heart and spiritual belief.

The day following Jody's death I rushed to the therapist office seeking any wisdom and comfort she could offer. "Patty, I have Jody's permission to tell you what she said at our last meeting and I want to share it with you now." Leaning forward, taking my hand, she told me Jody's last request: "please don't let anything happen to my Mom."

I hereby declare under penalty of perjury under the laws of the State of Oregon and the United States that the above statement is true and correct.

Dated: November 2, 1996
Place of execution: Bend, Oregon

/s/
Patty Rosen

PERSONAL DECLARATION OF
JEFF (JOSEPH) HALSEY

My name is Jeff Halsey. My address is 1000 - 8th Avenue, #A 806, Seattle, Washington 98104. My date of birth is April 5, 1958.

I prepared this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My partner Danial Danzer's biggest fear was that of losing his mind. He wanted to die before he lost his mind.

Danial had reached the final stages of AIDS. He sought help with his problems from the medical community but didn't receive any. So when he felt his mind was leaving him, he opted for a unique solution to his problem, that being withholding his insulin and letting himself die of insulin shock. It was a very long five days of convulsions, dementia, violent outbreaks, and a total loss of self-dignity.

I feel that had there been a way for him to end his life peacefully, that he would have opted to do so. Danial was lucky in that he had a way to deliver himself--by withholding his insulin. Most people are not that lucky. Most people must suffer even more than Danial suffered.

I couldn't wait for him to die so that he would quit suffering and I would quit suffering. I feel that Danial and I were both robbed of important, quality time by his slow and painful death. He might have been spared some of his greatest pain and retained his dignity if he and his physician had received help from a compassionate code of laws.

He was only 34 years old when he died on June 10, 1994.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 1, 1994

Place of execution: Seattle, Washington

/s/
Jeff Halsey

PERSONAL DECLARATION OF TANIA BLOOM

My name is Tania Bloom. My address is 3110 C Portage Bay Place E., Seattle, Washington 98102. My date of birth is September 28, 1936.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

In 1989, my father was dying of lung cancer and was in excruciating pain. His doctor would not provide pain medication other than Tylenol saying that to do so "would not be medically advisable." Father remained at home and in spite of being hooked up to oxygen, he struggled to breathe. We had access to morphine and hinted to hm that we could get it for him if he wanted it. However, he refused because he knew it was illegal to assist in a suicide.

When he realized that my family was going to be away for a day, he wrote us a beautiful letter, went down to his basement, and shot himself with his 12-gauge shotgun. He was 84.

My youngest daughter did not have the benefit of having her own father during her growing up years so my father became her surrogate father. They became extremely close. The loss of her grandfather was devastating for her. The nature of Dad's suicide added to this tragedy. This was a brutal and awful experience for my children and for me. I felt a great deal of loss, anger, and remorse about a system that would not allow my father to die gracefully and with dignity.

My son-in-law then had the unfortunate and unpleasant task of cleaning my father's splattered brains off the basement walls.

Physician assisted suicide should be a rational choice and a reassurance for people. Physician assisted suicide can have safeguards and planning so that it wouldn't be an impulsive,

irrational act and one of unnecessary violence such as that of my Dad's.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: July 28, 1994

Place of execution: Seattle, Washington

/s/
Tania L. Bloom

PERSONAL DECLARATION OF GAIL BERENY

My name is Gail Bereny. My address is 2360 - 43rd Ave. E., #307, Seattle, Washington 98112. My date of birth is _____.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

Several years ago, my 80 year old father was diagnosed as having terminal abdominal cancer. He went to his doctor with two requests, (1) not to prolong things, and, (2) to keep him as pain free as possible. His doctor agreed. However when time came, the doctor did neither. And so my father, to whom dignity was very important, lay dying, diapered, moaning in pain, begging to die. I called the doctor's office, crying, begging him to relieve Dad's pain. He refused, saying morphine could kill him.

My father's brother, my uncle, has a weak heart. He was so distraught that we were frightened for him. Dad's friends did what they could to give him their that love and support. His best friend, a retired cardiologist, was dismayed and angered at the physician's lack of help and compassion. Dad would have been spared at least a week or two, the worst part of his illness.

I felt very guilty then, and feel guilty now, about Dad's terrible death. I feel guilty that he died in so much pain and with no dignity left. The doctor had the means to give him a gentle, painless death. I have been left with frustration, anger, regret, and sadness. He had been a very good father.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: July 28, 1994
Place of execution: Seattle, Washington

/s/
Gail Bereny

PERSONAL DECLARATION OF
DOROTHY B. HOOGSTRAAT

My name is Dorothy B. Hoogstraat. My address is Beaverton Oregon. My date of birth is February 9, 1921.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My husband, Emerson E. Hoogstraat, a retired Professor of Finance, from Portland State University, died on March 25, 1995 of prostate cancer that had spread to the bones. He had been diagnosed in March of 1993 as having prostate cancer. We obtained a second opinion and he decided to have surgical removal. The physician did not complete the surgery as the cancer had spread to the lymph nodes. He then had forty radiation therapy treatments and after a few months of relatively pain free existence he again began having problems. In late 1993 he had edema in the right leg from hip to foot, caused by tumors pressing on the blood vessels in the groin and at the suggestion of his urologist had an orchiectomy, which we hoped would relieve the swelling in his leg and slow the spreading of the cancer. He was relatively comfortable until June of 1994 when a series of new problems developed. Following further diagnostic procedures it was ascertained that the cancer had spread to his ribs, spine and right femur. He was in considerable pain when walking, sitting or lying in bed. He had been given medication for the pain prior to this time but it now became a necessity if he was to have any measure of relief. His ribs gradually broke, and as he said to me many times, he could feel the broken edges of the bones rub together as he would sit or attempt to arise from the bed. He was in unbearable pain. He was an extremely intelligent, courageous and dignified man and he did not wish to suffer unbearable pain when there was no hope of recovery from this condition. He would very much like to have gone to sleep in his own bed and not had to suffer further. He felt that it was his right to say when he had suffered enough. He "lived" at least two months after he would have preferred not to. The physicians and Hospice people were constantly changing medications and attempting to make him as

comfortable as possible - which in his condition was an impossibility. It was a twenty-four hour a day caregiving situation and he still suffered unbearably. He remained at home until his death.

He had been very active in promoting Measure 16 - we both had - and he was sad that he was unable to receive help when he so desperately wished and needed it!

We had been married for forty-seven years and shared a lifetime together, and truly, watching him suffer and being unable to do anything for him that would relieve his pain, was for me devastating.

I do not believe it is suicide when a person is terminally-ill and there is no relief for the pain and suffering. Quality of life is very important.

I do not believe that God intended for people to suffer in this manner. We are more compassionate with our pets than we are with our dearly loved family members.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above are true and accurate.

Dated: October 30, 1996
Place of execution: Beaverton, Oregon 97005

/s/
Dorothy B. Hoogstraat

PERSONAL DECLARATION OF GÖSTA PEARSON

My name is Gösta Pearson. My address is 7432 Latona Avenue NE, Seattle, Washington 98115. My date of birth is June 29, 1925.

I prepare this declaration to support the position of Compassion in Dying in the case of Compassion in Dying v. State of Washington.

In 1991, I was with my very good friend, Hugo Vila, when he died. Hugo moved to the United States from Cuba and became an American citizen. He had no family members in the United States and I became a surrogate father to him.

I spent the last few weeks of Hugo's life with him, as he slowly but steadily was dying from AIDS. Hugo remained living in his apartment and I spent several hours each day helping take care of him. At the end, he could not walk and could only use one of his arms. I think he had suffered a stroke which paralyzed one side of his body. He had a catheter attached to him and he was unable to control his bowel movements. Hugo was very upset about messing himself in bed, since he had always been a meticulous person. I had to pick Hugo up, put him in a wheelchair, take him to the bathroom and lift him up and put him in the bathtub, in order to clean him. Hugo had lost a lot of weight and was virtually skin and bones the last few weeks of his life. Hugo needed help in eating and in doing virtually everything in order to continue living.

Hugo told me that he was very concerned about his loss of dignity and ability to care for himself. He was mentally alert and not depressed during this period. Medication controlled his pain, but the loss of dignity was horrible to him. He told me that he had had a full life and he wanted to end his life with dignity, realizing that things were only going to get worse as his AIDS progressed.

On June 20, 1991, Hugo told me that he had decided to take his own life with some pills he had stockpiled. He told me I did not have to stay with him, but I wanted to be by his side. He

prepared two glasses of medication and told me he was going to drink one glass and then follow with the other. He then drank all of one of the glasses. He then told me that "that didn't taste very good--will you get me a spoon of pudding from the kitchen". I did and he said "that's better." Then he reached for the second glass and passed out before taking the second glass of medication.

Hugo was in a coma for the next several days. I immediately called his physician, who came and examined him. Hugo remained in his home, receiving no food or hydration. Medical personnel told me that Hugo could hear us, even though he was not responding to us.

This was the worst seven days of my life. It was miserable for me, for Hugo, and for others to see his desired death stretched out for so long. I slept in his apartment during that week in order to be close to him.

If Hugo had been able to have a physician assist him in his dying, he could have died when and how he wanted, with dignity and without further complications and problems.

A program should be able to be developed so that people don't make the same bungling mistakes Hugo did. It is important for people in Hugo's situation to have the freedom of choice to end their life, without fear and without complications which make their dying process a nightmare.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above mentioned is true and correct.

Signed: /s/

Dated: November 21, 1996

Place of execution: Seattle, Washington

DECLARATION OF KEITH WILLIAM GREEN

1. My name is Keith William Green and I live in Los Angeles, California.

2. I prepare this declaration to support the position of Compassion in Dying in the case of Compassion in Dying vs. State of Washington.

3. I was arrested on December 4, 1995 in West Los Angeles after my lover of eight years committed suicide. Within hours of the arrest, I was charged with murder under California Penal Code section 187 and felony assisted suicide under California Penal Code section 401. I was a defendant in the matter entitled People v. Keith William Green, Los Angeles Municipal Court, West Los Angeles District, Case Number SA023990.

4. In 1991, my lover tested positive for the human immunodeficiency virus ("HIV") and was diagnosed with full blown AIDS in early 1994. He was in the advanced final stages of the disease at the time of his demise. With his immune system entirely compromised he suffered from a panoply of debilitating diseases which were incurable. During that time, I was his primary caregiver, constant companion and, more often than not, his sole source of emotional support.

5. Throughout the last year of his life, he suffered from a variety of ailments including Cytomegalovirus ("CMV") retinitis, an especially frightening condition in which the virus attacks the optic nerve. It had rendered him virtually blind in one eye and was threatening to cause total blindness in both. He suffered from bacterial infections that caused chronic night sweats, fever, chills, malaise, nausea, diarrhea and pain. He had been treated for CMV Colitis by daily intravenous infusions of Foseavir, and suffered from neuropathy, the primary symptom of which is pain throughout the extremities. He could not drive, he could not work, he could not live without pain and anxiety, and he had lost control of most bodily functions.

6. Having witnessed the deaths of many of our friends from AIDS, he was aware of his fate. He unsuccessfully attempted suicide in July 1995 by the ingestion of drugs that he had quietly stockpiled. After several hours of distress and seizure it became apparent that his attempt was flawed so I called 911. Because of his attempt at suicide, he was confined by restraints to a bed at the UCLA Medical Center. It was a horrible experience for the both of us. In the end, the failed attempt only served to increase his sense of helplessness, humiliation and resolve to die on his own terms.

7. He left numerous notarized suicide notes indicating that it was his desire to end his life, that he had made the decision on his own, that the reason was the lack of quality in his life, and he even promised to sue anyone who attempted to revive him.

8. In late November, 1995, he was hospitalized again, with his doctors encouraging surgery on the one eye from which he still had some sight. Fearful that the surgery would render him totally blind, he refused the procedure and left the hospital against medical advice on or about December 1, 1995.

9. On Monday, December 4, 1995, he told me that this would be our last morning together. He went into the bathroom where he remained for a considerable period of time. I learned afterwards that he had been taking a large and lethal quantity of chlorohydrate and seconal. Because his prior attempt at suicide by pills had failed, he had planned to use carbon monoxide as a back up.

10. After a tearful goodbye, he went to the garage where he had set up his car in a manner as to facilitate the ingestion of carbon monoxide. Once seated in the driver's side of his car, he then told me that it was time for me to leave.

11. I left our home and began to drive aimlessly, but was haunted by something he had asked me to promise again and again during our last year together. He had repeatedly asked me to promise him that I would not leave him as his condition worsened. I, in turn, made a commitment that I would indeed never leave him. Unable to silence the memories of these words, I returned to our

home within five to ten minutes of leaving. I went to the garage which was then filled with smoke and stayed with him in the car.

12. Given the circumstances, his decision to commit suicide could hardly be described as anything but a rational choice. Indeed, it was his fundamental natural right. In the same way, it was my right to be by his side, not only to honor the promise made, but also to honor our love and admiration for each other.

13. After having been prosecuted for a felony for six months, the charges were finally dismissed on June 4, 1996. Though released on my own recognizance within a few days of having been arrested, the terms and conditions of my release precluded me from being at his funeral in his home town in Texas as I was not allowed to leave California.

14. I am the one person who stayed by him while everyone else abandoned him as his condition worsened. I am the one person whose love was sufficient to withstand the horrible strain caused by his progressive illness. Despite all that, I am also the one person who was charged with a felony and faced a prison term of up to three years. In the end, the charges that were filed against me were the last thing that he would have ever wanted to happen.

I hereby declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 28th day of November, 1996, at West Hollywood, California.

/s/
KEITH WILLIAM GREEN

DECLARATION OF WILLIAM F. MEYER III

My name is William F. Meyer III. My address is 2 Teragram Place, Westport, Connecticut 06880. My date of birth is April 27, 1929.

I prepare this Declaration to support the position of Compassion in Dying in the case of Compassion in Dying v. State of Washington.

In 1991, my father, William F. Meyer Jr., who was 88 years old and had experienced five cancer operations, was in rapidly failing health. The cancer that had begun in his colon had spread to his lungs. He was losing weight and was being eaten away. His doctor said he had only a few months to live.

My father approached me with the idea of taking his life, a suggestion that I immediately rejected since he was my best friend and advisor. For the next several weeks during weekly visits and telephone conversations, I tried to change his mind. After discussing my father's decision with several close friends, plus my minister, who is my spiritual leader (and who talked to my father), I reluctantly agreed to my father's wish. He took many of his close friends, plus selected relatives, into his confidence concerning his intention, and he even prepared a letter which I was to mail to 80 friends and relatives after he had taken his life. The letter said "I happily decided that it was more kind and thoughtful of me to terminate my life before I reached a decadent condition of helplessness."

After my father and I met with my father's doctor of 25 years, my father decided he would use the procedure featured in the book Final Exit, taking 12 sleeping pills and placing a plastic bag over his head.

My father's first attempt at this action failed when his reflex action, which comes from the feeling of suffocating, caused him to pull off the plastic bag. When I returned to my father's home the next morning, he was awake and distressed that he was still alive.

My father consulted with his doctor and was advised that I could hold my father's hands so the reflex action would not remove the plastic bag. My father and I followed this procedure and he was able to end his life.

Since one of my father's last requests was that I tell his story, I joined the Hemlock Society and became a vocal spokesman for death with dignity. In the summer of 1994, I was interviewed for a story by Connecticut Magazine. After the story, I was arrested and charged by the police with second degree manslaughter. If convicted, I faced ten years in prison.

At a hearing in December, 1994, before a Superior Court judge in Hartford, Connecticut, two ministers and several friends spoke on my behalf. Numerous people, including eleven ministers and eighteen doctors, wrote to the judge to support me. Even though the District Attorney pleaded that my case go to trial, the judge stated that although I had broken the law, I was following my father's wishes, and the judge considered me an outstanding citizen. I was given two years "accelerated rehabilitation" (after two years, all charges are dropped, with no record).

I was and am still amazed at how many people relate stories of prolonged, painful suffering of relatives or friends. They called my story an act of courage and common sense. There is a legion of people who live with a "secret agony" over watching a loved one waste away.

From a religious standpoint my act of love for my father is consistent with my church's beliefs. As a most loyal and active member of the United Church of Christ, I concur with our statement, "We affirm individual freedom and responsibility to make choices in these matters."

I hereby declare under penalty of perjury of the laws of the State of Connecticut and the United States that the above statement is true and correct. Executed at Westport, Connecticut, on _ December 2, 1996 _.

/s/
William F. Meyer III

PERSONAL DECLARATION OF
STEVE KNIPP

My name is Steve Knipp. My address is 150 Melrose Ave. E., #102, Seattle, Washington 98102. My date of birth is May 28, 1962.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

My partner, Tom Andolina, was diagnosed with AIDS in February, 1990. His condition worsened to the point that he was homebound and in a great deal of pain. Pain medications were not working. Doctors would not prescribe medications to help him end his life so he was forced to stockpile medications until he had enough. He died on December 1, 1991, alone, because of fear of anyone stopping him if they were present.

We had planned on the time and the day. He was so wrapped up for so many weeks planning his exit that he was unable to enjoy what life he had left. He was very frustrated at how to commit suicide; he didn't know how. There was no way that we could find out how much medication he would need. We both struggled with it for months. He didn't want to do anything violent or painful. We didn't want him to commit suicide, but he was in too much pain and had become housebound. The quality of his life was severely diminished. He also had a fear that if he failed in his attempt, he would be resuscitated.

Because he was afraid of my reaction, he decided to do it alone. It was a terrible shock to wake up one morning and find him dead in the livingroom. He had been dead for eight hours. I was obviously devastated. We had been partners for ten years. Our friends were very upset that they couldn't be with him to say goodbye.

It was a very lonely death. That's the one thing I will never get over. My mother came from out-of-state to be with me for a

period of time as she was concerned for my emotional health. I was in therapy for six months.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: July 31, 1994

Place of execution: Seattle, Washington

/s/
Steve Knipp

PERSONAL DECLARATION OF
JINNY TESIK

My name is Jinny Tesik. My address is 3307 N.E. 125th, Seattle, Washington 98125. My date of birth is April 20, 1942.

I prepare this Declaration to support the position of the Appellees in the case of Compassion in Dying v. State of Washington.

In 1986, I took a leave of absence from my position on a Seattle Hospice Team to help my father care for his terminally ill wife (my stepmother) of 36 years. She died slowly and stoically from lung cancer. We were with her at home when she died. For over two years, Dad watched his handsome wife succumb to the ravages of the disease. He honored the choices she made in her care and treatment even though they wouldn't have been what he would have chosen for himself.

Unable to live alone due to his own battle with emphysema, Dad lived with me for the last two years of his life. He was adamant that he would not let his disease control him the way his wife's lung cancer controlled her. He intended to take his life while he still had his dignity, self-respect, and , above all, was still in control of his life. He made me promise that I would honor his choice. He threatened that if the means for him to take control of his death were not available, he would kill himself with a kitchen knife.

The emphysema progressed. Dad was tethered to 30 feet of oxygen tubing; he seldom left his bedroom. Breathing became more difficult and eating became a problem. His physician was totally opposed to providing the help Dad requested. One morning, he reminded me of my promise to help him. He discussed his plan rationally, non-emotionally. He was ready to die and needed my support. We raided the medicine cabinet and I was sent out to buy some vodka. We spent the day together. Toward evening, he asked me to leave the house and not return until very late. He did not want me to be implicated in any way in his suicide. Saying

goodbye to my dad was one of the saddest times of my life. And I had to go through that long night alone for I, in turn, could not implicate anyone else in the knowledge of my dad's death. He died in 1990 at the age of 76.

My 39 year old husband committed suicide violently ten years ago by shooting himself in the head. That is the kind of suicide that leaves the legacy of guilt, anger, and unanswered questions. That kind of suicide devastates and destroys those left behind.

After 12 years of working in hospice and as a grief counselor, I have heard far too many cases of others like my father who chose to be in control of their deaths. For those who choose their own death in their own time, let it be peaceful, loving and legal, not shattered by violence and shame.

I hereby declare under penalty of perjury of the laws of the State of Washington and the United States that the above statement is true and correct.

Dated: August 1, 1994

Place of execution: Seattle, Washington

/s/

Jinny Tesik

(58) (60)

Nos. 96-110 and 95-1858

Supreme Court, U.S.
FILED
DEC 10 1996
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

STATE OF WASHINGTON, et al.,

Petitioners,

vs.

HAROLD D. GLUCKSBERG, M.D., et al.,

Respondents.

DENNIS C. VACCO, ATTORNEY GENERAL OF THE STATE OF NEW YORK, et al.,

Petitioners,

vs.

TIMOTHY E. QUILL, M.D., et al.,

Respondents.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE SECOND AND NINTH CIRCUITS

BRIEF OF THE WASHINGTON STATE PSYCHOLOGICAL ASSOCIATION, THE AMERICAN COUNSELING ASSOCIATION, THE ASSOCIATION FOR GAY, LESBIAN AND BISEXUAL ISSUES IN COUNSELING, AND A COALITION OF MENTAL HEALTH PROFESSIONALS AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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December 10, 1996

61 pp

QUESTION PRESENTED

Whether a State may prohibit physicians, completely and under any set of circumstances, from providing mentally competent, terminally ill adults with the means medically necessary to choose the manner and timing of their death.

TABLE OF CONTENTS

Page

QUESTION PRESENTED i

TABLE OF AUTHORITIES iv

INTEREST OF THE AMICI 1

SUMMARY OF ARGUMENT 3

ARGUMENT 6

I. Recognition And Implementation Of The Constitutional Right At Issue In These Cases Depends On The Ability To Assess Whether A Terminally Ill Patient Is Mentally Competent, And Whether Such A Patient Is Acting Rationally And Voluntarily When He Or She Seeks Assistance In Choosing The Time And Manner Of Death. 6

II. Mental Health Professionals Are Guided In Their Approach To End-of-life Issues By Ethical Principles That Include Patient Autonomy And Self-determination, Balanced By Legal Norms And Concern For Public Welfare. 8

III. It Is Possible To Assess Whether Or Not A Terminally Ill Patient Who Has Requested Assistance In Hastening Death Is Mentally Competent And Has Made A Reasoned, Informed, And Voluntary Decision To Seek Such Assistance 10

A. Assessing Capacity to Make Reasoned Decisions 10

B. Assessing the Rationality of a Decision . 14

1. *"Inherent irrationality"* 15

2. *Correlation with mental illness* . . . 19

C. Assessing the Voluntariness of a Decision 25

CONCLUSION 30

TABLE OF AUTHORITIES

CASES ***Page(s)***

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441 U.S. 418 (1979) 10, 11, 13

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116 S. Ct. 1373 (1996) 10, 11, 13

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497 U.S. 261 (1990) 11, 14

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Compassion in Dying et al. v. *State of Washington et al.*,
79 F.3d 790 (9th Cir. 1996) 6, 21

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80 F.3d 716 (2d Cir. 1996) 7, 21, 27

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IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1996

No. 96-110

STATE OF WASHINGTON, et al., *Petitioners*,

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HAROLD GLUCKSBERG, M.D., et al., *Respondents*.

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INTEREST OF THE AMICI[1]

Any consideration of the question before the Court in this case must involve the related issues of (i) whether a mentally competent adult patient would ever freely choose to hasten death, and (ii) whether it is possible to ascertain that a particular patient is mentally competent, adequately advised, and has freely made such an irrevocable choice. The amici are mental health professionals whose training and experience qualify them to provide the Court with insight on these important questions.[2]

The Washington State Psychological Association ("WSPA") is a non-profit professional association of approximately 900 doctoral level psychologists, and other related mental health practitioners. The WSPA's mission is to support, promote and advance the science and practice of psychology in the public interest. Many WSPA members work in areas directly affected by the issues raised by physician-assisted suicide, and confront the problems faced by terminally ill patients and their families on a regular basis. WSPA members routinely assess the mental capacity of patients, including those who are terminally ill and those contemplating suicide. By reason of the skills, training and experience of its members, WSPA believes it can provide meaningful insight into the mental capacity of terminally ill patients and into the diagnostic and evaluative resources available to verify such capacity. While the existence of a constitutional right to die is a legal question beyond the

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[1] This Brief is being filed with the written consent of all parties in accordance with Sup. Ct. R. 37(2)(a).

[2] Mental health professionals include psychiatrists, psychologists, social workers, professional counselors and marriage and family therapists.

special expertise of WSPA, WSPA hopes to demonstrate that evaluative processes do exist for reliably assessing mental capacity, even for patients who are terminally ill, and even for patients who may contemplate suicide.

The American Counseling Association ("ACA") is the largest non-profit organization of professional counselors in the United States, with approximately fifty-five thousand members. ACA is an educational, scientific, and professional organization whose members are dedicated to the enhancement of human development throughout the life span, and who work to support and enhance the worth, dignity, potential and uniqueness of each individual. Indeed, the ACA's Code of Ethics and Standards of Practice states that "The primary responsibility of counselors is to respect the dignity and to promote the welfare of clients." Many of ACA's members provide mental health services, including psychotherapy and psychological assessments. Professional counselors serve in private practice, community mental health centers, mental health agencies, schools, universities, hospitals, rehabilitation facilities, business, industry, correctional institutions and religious organizations. ACA's members are trained in the diagnosis, etiology, and treatment of mental and emotional disorders, including depression. Given the counseling profession's largely unique focus on human development, and on individual self-determination and self-actualization, ACA feels it imperative to express its position regarding the ability of terminally ill adults to choose the manner and hasten the timing of their death.

The Association for Gay, Lesbian & Bisexual Issues in Counseling ("AGLBIC") is an association of gay and non-gay professional counselors seeking to promote greater understanding and insight toward counseling gay, lesbian and bisexual clients. AGLBIC offers professional training for all counselors interested in developing clinical skills that will

enable them to be more effective. AGLBIC's interest in these cases stems from its members' experience with gay, lesbian, and bisexual persons with HIV disease.

The Coalition of Mental Health Professionals Supporting Individual Self-Determination in Decisions to Hasten Death is an ad hoc group of academics, private practitioners, administrators and consultants. These individuals have training and experience in the mental health professions which makes it appropriate for them to offer their views on the possibility of free and rational choice in the context relevant to this case. All Coalition members have extensive experience providing psychotherapy, often to persons who are terminally ill, and/or strong records of research and writing on depression, grief, suicide, psychotherapy, personality disorders, and substance abuse. A list of Coalition members is attached to this brief as Appendix A.

SUMMARY OF ARGUMENT

The decisions of the courts of appeals in these cases limit their holdings to a narrow set of circumstances: cases involving mentally competent, terminally ill adults who have made, or wish to have the option to make, the choice to select the manner and hasten the time of an otherwise quickly and inevitably approaching death. Implementation of either decision therefore depends on the ability to assess whether a terminally ill patient is mentally competent, and whether a particular decision to seek assistance in dying is rational and voluntary. These central issues of the competence, rationality, and voluntariness of end-of-life decisions are ones with respect to which many mental health professionals have special training and experience.

Two central values for mental health professionals are the intertwined principles of client autonomy and self-determination. Mental health professionals do not promote

any particular resolution of the terminal-care issues that may arise near the end of a client's life. Rather, in the context of end-of-life decisions, clients are helped by providing them with the means to make informed choices.

In determining legal competence, courts have inevitably relied on the training, experience, and judgment of qualified mental health professionals to assess an individual's capacity to make reasoned decisions. In the context relevant to these cases, there is no dispute that States may appropriately set high standards for making such assessments. Under existing or suggested standards, an evaluator would focus, for example, on a patient's ability to make a coherent assessment of costs and benefits and to draw conclusions that are logically consistent with his or her own values, rather than on the particular outcome of the patient's deliberation. Once appropriate standards have been set, mental health professionals who have the requisite training, experience, and direct contact with an individual patient will be in a position to assess whether the patient has the capacity to make a reasoned end-of-life decision.

There should be no dispute that, before allowing a physician to assist a terminally ill patient to hasten death, a State may also constitutionally require some particularized assessment of the patient's end-of-life decision. Although some have argued that *any* decision to hasten the end of one's life must be either irrational or the product of mental illness, that argument is merely conclusory. Evaluation of particular decisions must instead focus first and primarily on the deliberative process involved, not on the decision ultimately made. Similarly, neither research nor experience supports the assertion that decisions to hasten death are so highly correlated with mental illness as to justify a prophylactic rule banning all physician assistance in dying. Rather, research indicating that terminal illness, particularly

if accompanied by intractable pain or other special circumstances, presents a special case for rational suicide is reinforced by studies showing that a significant proportion of mental health professionals believe that hastening death can be a reasonable choice. Under proper circumstances, a choice to control the manner and hasten the time of one's own death is neither inherently irrational nor indicative of mental illness.

Mental health professionals who work with terminally ill patients are as concerned as others that decisions to hasten death not be impulsive or ambivalent, and that they be made free from any coercion or undue influence. Such dangers may largely be avoided through appropriate state regulation, including mandatory waiting periods and the involvement of mental health professionals in evaluation and counseling. With a strong commitment to patient autonomy as a guiding principle, mental health professionals are uniquely suited to serve as counselors and advocates for terminally ill patients in the face of any improper pressure. Moreover, appropriate safeguards may be put in place without denying patients who are in a position to make free, informed, and intelligent end-of-life decisions the opportunity to do so.

Frank discussion of end-of-life issues among terminally ill patients, their treating physicians, and appropriate mental health professionals would necessarily raise the issues of capacity, rationality, and voluntariness discussed in this brief. The process of evaluation and counseling that should accompany any end-of-life decision will often lead patients to choose some option other than assisted suicide — even if the patient actively considers that course as one possibility. The cases before the Court involve what is presently, and is likely to remain, a minority of patients who reach a carefully considered decision to hasten the end of life, even after a thorough exploration of the alternatives. Nonetheless, various

considerations suggest that protection of the public would be enhanced, not diminished, by bringing physician assistance in dying into the open and allowing for comprehensive legal regulation.

ARGUMENT

I. RECOGNITION AND IMPLEMENTATION OF THE CONSTITUTIONAL RIGHT AT ISSUE IN THESE CASES DEPENDS ON THE ABILITY TO ASSESS WHETHER A TERMINALLY ILL PATIENT IS MENTALLY COMPETENT, AND WHETHER SUCH A PATIENT IS ACTING RATIONALLY AND VOLUNTARILY WHEN HE OR SHE SEEKS ASSISTANCE IN CHOOSING THE TIME AND MANNER OF DEATH.

This case presents the narrow but important question whether a State may constitutionally prohibit physicians, under any set of circumstances, from providing mentally competent, terminally ill adults with the means medically necessary to choose the manner and hasten the timing of their death. In the opinion below in No. 96-106, the Ninth Circuit recognized "a constitutionally protected liberty interest in determining the time and manner of one's own death." *Compassion in Dying et al.* v. *State of Washington et al.* 79 F.3d 790, 793 (9th Cir. 1996). The court then held that, in the particular context of a competent, terminally ill patient whose physician is willing to prescribe appropriate medication, that interest outweighs even the State's substantial general interest in preventing suicide. In that context, the court held, "the state has wide power to regulate, but it may not ban" willing physicians from providing medical assistance to a competent patient who chooses to hasten the already fast-approaching end of life.

In No. 95-1858, the Second Circuit reached a similar result through different reasoning. That court first determined that New York law recognizes and respects a terminally ill patient's right to refuse or order the discontinuance of life-sustaining treatment, including artificial nutrition and hydration. *Quill et al.* v. *Vacco et al.* 80 F.3d 716, 727-28 (2d Cir. 1996). The court then concluded that the State treats other competent, terminally ill patients unequally, by prohibiting even a willing physician from prescribing appropriate drugs if and when such a patient wishes to hasten the moment of his or her own impending death. *Id.* at 729. In the limited context of mentally competent, terminally ill patients, the court discerned no rational relationship between that inequality of treatment and any legitimate state interest. *Id.* at 730-31. The court therefore struck down the State's criminal prohibition on assisting suicide, as applied to "prohibit a physician from prescribing medications to be self-administered by a mentally competent, terminally ill person in the final stages of his terminal illness." *Id.*

Although the opinions below rest on different legal theories, both are notable for the care they take to limit their holdings to a narrow set of factual circumstances: cases involving mentally competent, terminally ill adults who have made, or wish to have the option to make, the choice to select the manner and hasten the time of a quickly and inevitably approaching death. Whatever the proper legal analysis, both decisions therefore depend on two important factual propositions: that it is generally possible for a competent person to make a reasoned decision to hasten the end of his or her own life, and that it is possible in any given case to assess the decision-making capacity of an individual patient and the soundness of his or her decision-making process.

Moreover, whether the right in question is guaranteed directly by the Constitution, or as a matter of parity with rights already afforded by a State to individuals who wish to terminate life-sustaining care, both decisions seek to protect a sphere of personal autonomy — specifically, an individual's right to choose the time and manner of ending the suffering caused by a terminal illness. That protection is only sensible or desirable, however, if the choice protected is in fact an autonomous decision made by the individual patient. Conversely, the State's interest in regulating, or even prohibiting, end-of-life decisions of this type increases to the extent that there is any uncertainty about whether a particular patient's choice is truly voluntary.

These central issues concerning the competence, rationality, and voluntariness of end-of-life decisions are ones with respect to which many mental health professionals have special training and experience. Moreover, the mental health professions have long grappled with the ethical issues that arise in this context. The amici offer the following observations to the Court in the hope that they will be helpful in informing the Court's decision on the important question presented by these cases.

II. MENTAL HEALTH PROFESSIONALS ARE GUIDED IN THEIR APPROACH TO END-OF-LIFE ISSUES BY ETHICAL PRINCIPLES THAT INCLUDE PATIENT AUTONOMY AND SELF-DETERMINATION, BALANCED BY LEGAL NORMS AND CONCERN FOR PUBLIC WELFARE.

The analysis provided in this brief is grounded in underlying ethical principles that guide the work of mental health professionals. Mental health professionals accord appropriate respect to individuals' fundamental interests in

privacy, self-determination, and autonomy, while remaining mindful that those interests may conflict with legal and other obligations. When conflicts occur, professionals attempt to resolve them and to perform their roles in a responsible fashion that avoids or minimizes harm. They are aware of their professional and scientific responsibilities to the communities and society in which they work and live. Professionals apply and make public their knowledge of mental health in order to contribute to human welfare. They work to identify and mitigate the causes of human suffering.

Two central values for mental health professionals are the intertwined principles of client autonomy and self-determination. In the context of end-of-life decisions, clients are helped by providing the means for them to make informed choices. Mental health professionals do not promote any particular resolution of the terminal-care or other issues that may arise near the end of a patient's life. Rather, mental health workers who have appropriate training and immediate involvement with those suffering from terminal illnesses can help patients to explore, ameliorate, cope with, or solve problems that interfere with the patient's own control over his or her life and death.

Professionals can, for example, help patients to address issues such as pain, depression, dignity, tranquility, financial concerns, and the effectiveness or futility of available medical treatments. In addition, they can assist the patient to communicate with other health care providers, family members, social service providers, or others concerning the patient's needs, concerns and preferences, to help ensure that the patient receives necessary support and that the treatment provided comports with the patient's wishes. Finally, professionals can promote and monitor appropriate involvement by significant others in a patient's end-of-life decisions, and they can counsel both patients and survivors

in the inevitable process of grieving. *See generally, e.g.*, National Association of Social Workers, *Client Self-Determination in End-of-Life Decisions, in* Social Work Speaks: NASW Policy Statements 60 (3d ed. 1994) "NASW *Statement*", (reprinted as Appendix B hereto). In all these roles, mental health professionals seek to advance the ideals of client autonomy and self-determination, subject to the requirements of the law and concern for the general public welfare.

III. IT IS POSSIBLE TO ASSESS WHETHER OR NOT A TERMINALLY ILL PATIENT WHO HAS REQUESTED ASSISTANCE IN HASTENING DEATH IS MENTALLY COMPETENT AND HAS MADE A REASONED, INFORMED, AND VOLUNTARY DECISION TO SEEK SUCH ASSISTANCE.

A. Assessing Capacity to Make Reasoned Decisions

Both decisions below begin with the assumption that a terminally ill patient who seeks assistance in choosing the means and time of his or her own death must be "mentally competent" to make that final decision. Similar situations involving the assessment of mental competence or capacity arise in a variety of legal contexts, from competence to stand trial to competence to make a valid will. *See, e.g., Cooper* v. *Oklahoma*, 116 S. Ct. 1373 (1996) (competence to stand trial); *Addington* v. *Texas*, 441 U.S. 418 (1979) (involuntary civil commitment); Cal. Prob. Code § 812 (West Supp. 1996) (specifying criteria to be used in determining legal incapacity to perform various acts, including "to contract, to make a conveyance, to marry, to make medical decisions, to vote, or to execute wills or trusts."). Competence is a legal

question, which, when disputed, must ultimately be resolved by the courts. In deciding such issues, however, courts have inevitably relied on the training, experience, and expert judgment of qualified mental health professionals to assess a given individual's capacity to make reasoned decisions. *See, e.g., Medina* v. *California*, 505 U.S. 437, 450 (1992); *see also id.* at 465 (Blackmun, J., dissenting).

Particular legal standards of competence vary depending on the rights and interests at stake in a given context. *See, e.g., Cooper*, 116 S. Ct. at 1383-1384 (contrasting standards for involuntary commitment and for competence to stand trial). In the context of patients' end-of-life decisions, there is no dispute that the standards for assessing decision-making capacity and legal competence may appropriately be set high. *Cf. Cruzan* v. *Director, Missouri Dep't of Health*, 497 U.S. 261, 282-284 (1990); *Addington*, 441 U.S. at 423 ("The function of a standard of proof . . . is to 'instruct the factfinder concerning the degree of confidence our society thinks he should have in the correctness of factual conclusions for a particular type of adjudication.'"). While each State could establish its own standards and procedures for such cases, the mental health literature suggests that an appropriate standard would require that a terminally ill patient be able to:

(a) understand and remember information relevant to an end-of-life decision;

(b) appreciate the consequences of the decision;

(c) indicate a clearly held and consistent underlying set of values that provide some guidance in making the decision; and

(d) communicate the decision and explain the process used for making it.

See J. Werth, *Rational Suicide? Implications for Mental Health Professionals* 94 (1996).[3] A strict standard might also require that

> "once understanding [of the information relevant to an end-of-life decision] has been attained, the patient's rational manipulation of information [must take] place in the context of the patient's appreciation of the nature of his situation."

Appelbaum and Roth, *Competency to Consent to Research*, 39 Archives Gen. Psychiatry 951, 954 (1982).

Under this type of standard, a mental health professional evaluating decision-making capacity would examine a patient's "chain of reasoning," and would seek to determine whether the patient can "indicate the major factors in his decisions and the importance assigned to them." Appelbaum and Grisso, *Assessing Patients' Capacities to Consent to Treatment*, 319 New Eng. J. Med. 1635, 1636 (1988). The evaluation would focus on the patient's ability to make a coherent assessment of costs and benefits, and to draw conclusions that are logically consistent with his or her own values or other stated premises for the decision, rather than on the outcome of the patient's deliberation. *See also* Annas and Densberger, *Competence to Refuse Medical Treatment:*

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[3] *See also, e.g.*, Drane, *The Many Faces Of Competency*, 15 Hastings Center Report No. 2, 17, 19 (1985); Freedman, *Competence, Marginal and Otherwise; Concepts and Ethics*, 4 Int'l J.L. and Psychiatry 53, 59-60 (1981); Roth et al., *Tests Of Competency To Consent To Treatment*, 134 Am. J. Psychiatry 279, 280-282 (1984); Tepper and Elwork, *Competence To Consent To Treatment As A Pyscholegal Construct*, 8 Law and Human Behavior 205.

Autonomy vs. Paternalism, 15 U. Tol. L. Rev. 561, 568 (1984).[4]

Once an appropriate standard has been set, mental health professionals who have the requisite training, experience, and direct contact with an individual patient will be in a position to assess, in the first instance, whether a patient has the capacity to make a reasoned end-of-life decision.[5] Many

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[4] Compare Cal. Prob. Code § 813 (West Supp. 1996):

> A person has the capacity to give informed consent to a proposed medical treatment if the person is able to do all of the following:
>
> (a) Respond knowingly and intelligently to queries about that medical treatment.
>
> (b) Participate in that treatment decision by means of a rational thought process.
>
> (c) Understand all of the following items of minimum basic medical treatment information with respect to that treatment:
>
> (1) The nature and seriousness of the illness, disorder, or defect that the person has.
>
> (2) The nature of the medical treatment that is being recommended by the person's health care providers.
>
> (3) The probable degree and duration of any benefits and risks of any medical intervention that is being recommended by the person's health care providers, and the consequences of lack of treatment.
>
> (4) The nature, risks, and benefits of any reasonable alternatives.

See also Calif. Prob. Code § 1881 (West Supp. 1996) (standards of informed consent for conservatees).

[5] This Court has commented that "the subtleties and nuances of psychiatric diagnosis render certainties virtually beyond reach in most situations." *Medina*, 505 U.S. at 451, *quoting Addington*, 441 U.S. at 430; *see also Cooper*, 116 S. Ct. at 1382. In this context as in other areas of law (or medicine), however, the impossibility of certainty does not obviate the need to decide. *Id.* at 1382-83. The nature of end-of-life decisions would certainly justify a State in adopting a legal standard

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mental health professionals have extensive experience in making both formal written evaluations and ongoing, informal assessments of decision-making capacity and rationality during the course of psychotherapy, counseling, or psychiatric consultation in medical settings. Indeed, professional evaluation occurs continuously during therapy and within the context of hospital or outpatient consultations. Is the client sensing, perceiving and comprehending information regarding his or her situation accurately? Is the client realistically formulating and utilizing this information? Are the client's perceptions being unduly influenced by mental disorders, prescribed medications, substance abuse, or external social or economic pressures? Overall, is the client fully informed and rational? General criteria exist, and specific criteria may be adopted, for making such evaluations in the case of terminally ill patients who seek physician assistance in controlling the manner and timing of their deaths. *See*, *e.g.*, J. Werth, *supra*, at 94-95. Specification and refinement of those criteria, and their application in particular instances, are well within the competence of the mental health profession.

B. Assessing the Rationality of a Decision

Even if a person generally has the capacity to make reasoned judgments, he or she may make particular choices that are unduly influenced by factors not associated with rational decision-making, such as coercion, inadequate treatment, prescribed medications, drugs, alcohol, or mental disorders. There should be no dispute that, before allowing

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[5](...continued)
under which close cases are resolved in favor of preserving the medical status quo. *See Cruzan*, 497 U.S. at 283. But the inevitability of close cases cannot, by itself, justify imposing a flat prohibition that will apply even in cases where the evidence of mental capacity is clear.

a physician to assist a terminally ill patient in selecting or hastening the moment of death, a State may constitutionally

require not only an assessment of general mental capacity, but some particularized assessment of the patient's end-of-life decision. If allowed to address the issue openly, without fear of legal or ethical repercussions, mental health professionals can provide such assessments. *See*, *e.g.*, Holtby, *Social Work, Suicide, and Self-Deliverance*, 1 National Social Work AIDS Network Readings and Writings No. 3, 30 (1996); Quill et al., *Proposed Clinical Criteria for Physician-Assisted Suicide*, 327 New Eng. J. Med. 1380, 1381-82 (1992); J. Werth, *supra*, at 55-80. Moreover, the involvement of mental health professionals and the use of open discussion and evaluation can facilitate the sort of full consideration that leads to an informed and deliberate decision, whatever it may ultimately be.

1. *"Inherent irrationality"*

It may be argued that *any* decision to hasten the end of life must be either irrational or a product of mental illness. *See*, *e.g.*, Brief for the American Suicide Foundation, Amicus Curiae, Supporting Reversal (Case No. 96-110) 5-11, 13 ("Am. Cur. Br. for the ASF"). That argument, however, assumes its conclusion. For example, one of the guiding principles for mental health professionals is client autonomy — allowing and encouraging clients to take control of their lives and assume responsibility for their decisions. In the argument for the inherent irrationality of suicide, however, a patient who chooses to forgo medical treatment is said to make only "a judgment about how to live before one dies," *id.* at 13, while a patient who desires to exercise essentially the same control over the final portion of his or her life by choosing the time and manner of death is characterized as "afflicted" by a "rigidity" that reflects

"impaired thought processes and irrationality," *id.* at 8. Similarly, the right to forgo treatment is treated as "rooted in our abhorrence of the violence inherent in forcing medical interventions on unwilling, competent adults," but the essentially identical choice to avoid the same "intense burdens, such as pain, bodily invasion, and the emotional suffering that can accompany . . . a course of treatment" by an active hastening of death is dismissed as necessarily a product of "mental impairment." *Id.* at 13-14. Thus, the argument succeeds only because it *defines* a request for active assistance in dying as "irrational."

As with determinations of competency and decision-making capacity, evaluation of a particular end-of-life decision must instead focus first and primarily on the deliberative process involved, not on the decision ultimately made. "If the reasoning process flows logically from its starting premises, though the result might be rejected by most people (*e.g.*, a person refusing potentially life-saving medical treatment), we cannot say that rational manipulation is impaired." P. Appelbaum and T. Gutheil, *Clinical Handbook of Psychiatry and the Law* 223 (1991). A patient who is fully informed, realistic, stable, and not mentally impaired — as determined, for example, by professional observation of the patient's behavior and ability to interact and communicate — may make a knowing and intelligent decision to decline (or accept) treatment, or to request (or decide against) assistance in dying. That is true even if the decision is based in part on "irrational" or super-rational factors, such as religious beliefs or other transcendent moral values.

To be sure, assessing the soundness of a terminally ill patient's decision to hasten death will sometimes present special challenges. In cases of terminal illness, the criteria for measuring the existence of mental disturbance are

particularly likely to be confounded by the effects of the physical disease itself. For similar reasons, it may be difficult to differentiate between normal grief — a reaction to actual or prospective loss — and clinical depression. *See* R. Neils, *Dying Well Network: Death with Dignity FAQs (Frequently Asked Questions)* § 4.18 (a copy of which has been lodged with the Clerk). Indeed, of the nine standard criteria for diagnosing a "major depressive episode," several may be present simply because of physical illness, and six may appear in a terminally ill patient simply because of natural grieving over the functional impairment caused by serious illness and over the impending loss of his or her life.[6]

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[6] The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* lists nine criteria for identifying a Major Depressive Episode. A grievously ill person who is not clinically depressed may meet criteria 2, 3, 4, 5, 6, and 9:

1) Depressed mood most of the day, nearly every day, as indicated by either subjective report (*e.g.*, feels sad or empty) or observation made by others (*e.g.*, appears tearful);

2) Markedly diminished interest or pleasure in all, or almost all activities most of the day, nearly every day (as indicated by either subjective account or observation made by others);

3) Significant weight loss when not dieting or weight gain (*e.g.*, a change of more than 15% of body weight in a month) or decrease or increase in appetite nearly every day;

4) Insomnia or hypersomnia nearly every day;

5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down);

6) Fatigue or loss of energy nearly every day;

7) Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick);

8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as

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With training and experience, however, a professional can distinguish clinical depression from physical illness or grief, for example on the basis of a patient's feelings of worthlessness or excessive guilt. An individual's sense of self-worth is typically unaffected by physical illness or grief, but significantly impaired in cases of clinical depression. Thus, a depressed patient might inappropriately request suicide precisely because of feelings of worthlessness and guilt. For a terminally ill patient, on the other hand, being able to assert some modicum of control over the course of an inevitable final illness, by choosing at least the time and manner of death, may be a final act of will that reflects — indeed, affirms — self-esteem and individual dignity. The differences between these situations may sometimes be subtle, but they are real, and mental health professionals who work with the terminally ill are qualified to assess them.

An assessment of any particular end-of-life decision should take into account not only the patient's ability to reason coherently, but also the information that the patient has considered in reaching his or her decision. Even if a patient receives fully adequate medical care, his or her physicians may be focused on the details of particular medical problems, rather than on the patient's entire circumstances. The patient will also inevitably be under considerable mental and physical stress. Mental health professionals can provide objective information and counseling about the patient's overall situation, including

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[6](...continued)

observed by others); and/or

9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicidal attempt or a specific plan for committing suicide.

American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders* 327 (4th ed. 1994).

alternatives of which neither the patient nor his or her attending physicians may be aware. *See* N. Peruzzi et al., *Ethics and Behavior* 8-13 (forthcoming 1997); *NASW Statement*, *supra*, at 60. They may, for example, be able to provide information about alternatives such as hospice programs, independent or assisted living arrangements, and potential sources of financial or other assistance. They can act as liaisons or patient advocates in coordinating comprehensive care. They are also well positioned to assess the patient's overall psychological state, and to recognize signs of misunderstanding, clinical depression, or other factors which suggest that the patient's decision-making ability may be compromised. They can offer the patient a sympathetic sounding-board, identify the factors that appear to be driving an end-of-life decision, and offer either confirmation that the facts are as the patient perceives them to be, or new or different information that may change or help to inform the patient's decision.

2. *Correlation with mental illness*

Even if some decisions to request assistance in dying may be fully informed and intelligently made, it may be argued that a decision to hasten death is so highly correlated with mental illness that the State is justified in enacting a prophylactic rule banning all physician assistance in dying. *Cf.* Black and Winokur, *Suicide and Psychiatric Diagnosis, in* Suicide Over The Life Cycle: Risk Factors, Assessment, and Treatment of Suicidal Patients 135, 139 (S. Blumenthal and D. Kupfer eds., 1990) ("few suicides occurred in persons judged not mentally ill, suggesting that the 'rational' suicide is uncommon."). In fact, the correlation between all suicide

and mental illness may be overstated.[7] Even if the

[7] Research indicating that the majority of individuals who commit suicide have one or more mental illnesses may be misleading. Even accepting the data as reported, these studies also show that from 3%-12% of people who have killed themselves had no mental illness. Black and Winokur, *supra*, at 139; Clark and Horton-Deutsch, *Assessment in Absentia: The Value of the Psychological Autopsy Method for Studying Antecedents of Suicide and Predicting Future Suicides, in* Assessment and Prediction of Suicide 144, 148-49, 153-54 (R. Maris et al., eds., 1992). Other researchers report studies in which more than 25% of completed suicides did not have a mental disorder and could be considered rational. See R. Maris, *Pathways to Suicide: A Survey of Self-Destructive Behaviors* (1981); Meerloo, *The Multifarious Motivations for Suicide, in* Suicide and Mass Suicide 18, 25 (J. Meerloo ed. 1962); Patel, *Pathology of Suicide*, 13 Medicine, Science, and the Law 103, 106 (1973). After studying suicide notes, Tuckman, Kleiner, and Lavell stated that they "were impressed with the possibility that in a number of cases the suicide could have resulted from a conscious, 'rational' decision reached by weighing the pros and cons of continuing to live." Tuckman et al., *Emotional Content of Suicide Notes*, 116 Am. J. Psychiatry 59, 62 (1969). *See also* Shneidman et al., *The Suicide Prevention Center, in* The Cry for Help 6, 13 (N. Farberow and E. Shneidman eds., 1961) ("A large minority of suicides, usually older persons in physical pain, are logical and rational and not psychotic.")

Other studies suggest that the data linking suicide and mental illness may be oversimplified. Tanney noted that dramatic differences appeared when studies of the association between mental illness and suicide are broken down into general population surveys and hospital surveys. He reported that, on average, only 38% of completed suicides in the general population had a known history of mental disorder, while, on average, more than 80% of suicides in hospital-based surveys had a psychiatric disorder or history of care. Tanney, *Mental Disorders, Psychiatric Patients, and Suicide, in* Assessment and Prediction of Suicide 277, 283-84 (R. Maris et al. eds., 1992) Similarly, Temoche, Pugh, and MacMahon reported all the highest estimates (47%-94%) of the percentage of suicides who displayed prior evidence of mental illness come from studies done *after* the suicide occurred; in studies dependent

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correlation holds for suicides in general, however, the argument for a prophylactic ban is not persuasive in the context of end-of-life decisions by terminally ill patients. In that context, physician-assisted "suicide" is far less akin to what is commonly termed suicide — typically a violent self-destructive act related to feelings of worthlessness — than it is to the thoughtful decision to decline life-sustaining treatment. The latter is a choice that upholds and affirms the dignity of a fully lived life, and one that many States, including New York and Washington, have already recognized as worthy of legal recognition. *See, e.g., Compassion in Dying*, 79 F.3d at 817-20; *Quill*, 80 F.3d at 727-28.

In fact, a number of researchers and clinicians have recognized that terminal illness, particularly if accompanied by intractable pain or other special circumstances, presents a special case for "rational" suicide. *See, e.g.*, Siegel, *Rational Suicide: Considerations for the Clinician*, 54 Psychiatric Quarterly 77, 78 (1982) ("We need not argue the issue whether it is rational for an individual with painful terminal illness to refuse extraordinary life-saving measures or to more actively arrange to end his life. Most would agree it is rational."); Quill, *Physician-Assisted Death: Progress or Peril?*, 24 Suicide and Life-Threatening Behavior 315 (1994).[8] Moreover, research on suicide among the

[7](...continued)
upon objective criteria measured prior to the suicide, estimates of the correlation with mental illness were much lower (5%-22%). Temoche et al., *Suicide Rates Among Current and Former Mental Institution Patients*, 138 J. Nervous and Mental Disease 124 (1964).

[8] In one survey of 39 HIV-positive individuals, researchers concluded that more than two thirds had rationally contemplated suicide. Moreover, the desire to hasten death was not directly related to clinical depression

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terminally ill must be interpreted with caution, because the cases likely to be studied are those that can be readily identified as "suicides," whereas other research indicates that many hastened deaths among terminally ill patients are never documented as such. S. Jamison, *Final Acts of Love: Families, Friends, and Assisted Dying* 5-6 (1995); R. Ogden, *Euthanasia, Assisted Suicide, and AIDS* 71-83 (1994). As a result, the research cited by opponents of hastened death must be viewed within an appropriately restrictive context, and it must be realized that it may not be possible to generalize the results. Several of the Coalition members listed in Appendix A have experience with literally hundreds of individuals who have died of terminal illnesses, and each could relate numerous stories of assisted deaths that were not reported as suicides. These professionals and the others who are members of the Coalition have chosen to join in this submission in part because their work has convinced them that the assertion that anyone, including terminally ill individuals, who wishes to hasten his or her own death must be depressed or otherwise mentally impaired is simply not borne out by either research or experience.

Recent research has found that a significant percentage of mental health professionals believe that hastening death can be a reasonable choice, and even have experience working with individuals who have made such decisions. In a national survey of a random sample of members of the American Psychological Association's Division of Psychotherapy, 81% of the respondents (with a 50% response rate) stated that they believed that an individual

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[8](...continued)
as measured by the Beck Depression Inventory (the most widely accepted means of making swift diagnoses of depression). Jones and Dilley, *Rational Suicide and HIV Disease*, 8 Focus: A Guide to AIDS Research and Counseling 5 (July 1993).

could make a rational decision to control the time and manner of his or her own death. Werth and Liddle, *Psychotherapists' Attitudes Toward Suicide*, 31 Psychotherapy: Theory, Research and Practice 440 (1994). In another study, using a sample of psychologists who were members of the National Register of Health Care Providers in Psychology, 86% of the respondents (again with a 50% response rate) indicated that they believed in rational suicide. J. Werth, *supra*, at 47. Twenty percent of the participants in the latter study stated that they had worked with patients whose hastened deaths could be considered "rational" suicides in the sense described above. J. Werth, *supra*, at 53; *see also* Pope et al., *Ethics of Practice: The Beliefs and Behaviors of Psychologists as Therapists*, 42 Am. Psychologist 993, 1003 (1987).

Similar results have been found in surveys of psychiatrists. One study of physicians in Washington State found that of five categories of physicians, "psychiatrists were most supportive of" assisted suicide and euthanasia. Cohen et al., *Attitudes Toward Assisted Suicide and Euthanasia Among Physicians in Washington State*, 331 New Eng. J. Med. 89, 91-92 (1994) (especially graphs). A more recent report found that two-thirds of the respondents to a survey of Oregon psychiatrists (with a 77% response rate) "endorsed the view that a physician should be permitted, under some circumstances, to write a prescription for a medication whose sole purpose would be to allow a patient to end his or her life." Ganzini et al., *Attitudes of Oregon Psychiatrists Toward Physician-Assisted Suicide*, 153 Am. J. Psychiatry 1469, 1469 (1996).

For these reasons, we think it must be accepted that a decision by a terminally ill patient to hasten his or her own death may be carefully considered and fully rational — just as it may be ill informed or the product of impaired

reasoning. Given the opportunity, mental health professionals are capable of assessing the nature and quality of a patient's decision-making process, and therefore of helping to determine that any decision that is implemented is a product of the patient's knowing and intelligent choice.

The decisions below would permit, perhaps for the first time, a process of free and open discussion and consultation among patients, their physicians, and mental health professionals concerning all end-of-life options. Indeed, States could and should, in our view, require such consultation in any case in which the patient's ultimate choice is to select or hasten the moment of death.[9] The mental health professionals involved would be in a position to assess the accuracy of the patient's understanding of his or her medical condition, including the prognosis and treatment alternatives; to review the quality of the patient's deliberative process; and therefore to evaluate the psychological soundness of his or her final choice. Under proper circumstances, a choice to control the manner and

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[9] Oregon's "Death With Dignity Act," for example, adopted by the State's voters on November 6, 1994, requires a physician to refer a patient who requests aid in dying to counseling if the physician believes that the patient may be depressed or otherwise mentally compromised. 1995 Or. Laws Ch. 3 (I.M. 16). The counseling is to consist of consultation with a licensed psychiatrist or psychologist to determine whether the patient is suffering from a psychiatric or psychological disorder, or from depression causing impaired judgment. We note that other mental health professionals, including social workers and professional counselors, who have appropriate training or experience in working with the terminally ill would also be capable of performing such evaluations. *See also* Baron et al., *A Model State Act to Authorize and Regulate Physican-Assistance Suicide*, 33 Harv. J. on Legis. 1 (1996), which proposes a specific series of procedural requirements designed to prevent mistaken decisions. In particular, the model act requires a review of the patient's competence by suitably trained mental health professionals.

hasten the time of death is neither inherently irrational nor indicative of mental illness. Rather, such a choice may be the final expression of a terminally ill patient's individual autonomy.

C. Assessing the Voluntariness of a Decision

The mental health professionals who work with terminally ill patients are as concerned as others that those patients who decide to hasten their own deaths make that decision free of any form of coercion or undue influence. They are equally concerned that a patient's choice may be merely impulsive, or that the patient may be so ambivalent that the simple passage of time is likely to change his or her mind. *See, e.g.*, Am. Cur. Br. for the ASF 9-10. Although these dangers are real, they may largely be avoided by appropriate state regulation of the process by which such individuals request and receive physician assistance, including mandatory waiting periods and the involvement of mental health professionals in the sorts of evaluations and counseling described above.[10] This may be accomplished without, at the same time, denying patients who are in a position to make free, informed, and intelligent decisions the opportunity to do so. Indeed, the active and open involvement of mental health professionals in counseling terminally ill patients about end-of-life issues may well be the best guarantee that *all* such patients will have the

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[10] For example, Section 3 of the proposed *Model Act to Authorize and Regulate Physician-Assisted Suicide* also contains requirements that "the request must be competent, fully informed, voluntary, and enduring." *See* Baron, *supra* note 8, at 26. The proposed statute also mandates that a professional mental health care provider "evaluate the patient to determine that his or her decision is fully informed, free of undue influence, and not distorted by depression or any other form of mental illness." *Id.* at 18.

information and support necessary to make their own decisions, based on their own values, about the course of their own treatment and, ultimately, their own manner of dying.

Assessments of whether a particular decision reflects independent determination or improper outside influence, like assessments of capacity to make reasoned decisions, are as familiar to mental health professionals as they are to the law. Mental health professionals are used to working, in a wide variety of contexts, with individuals who may be susceptible to pressure, suggestion, or intimations of authority. With a strong commitment to patient autonomy as a guiding principle, mental health professionals are uniquely suited to serve as counselors and advocates for terminally ill patients to protect against any improper pressure on this most sensitive of decisions. That is true whether the pressure in question arises from physicians, hospital administrators, third-party payers or "managed care" controllers, family members, or other inappropriate or treatable sources such as clinical depression, feelings of worthlessness, transient mental disorders, the effects of alcohol or other drugs, financial concerns, inadequate palliative care, or a lack of social support.

Concerns with respect to voluntariness and the risk of coercion apply equally in the case of terminally ill individuals who refuse, or request the discontinuation of, life-sustaining treatment. Those choices have nonetheless been made available to patients, under whatever safeguards individual States have deemed appropriate. Indeed, it is possible that recognition of the right at issue in these cases, together with the sort of independent counseling requirements that the States might be expected to enact in this context, would increase the level of information and support available to *all* patients, and thereby actually

decrease the number who choose to end their own lives. In any event, open discussion of end-of-life issues, and active involvement by mental health professionals, would significantly enhance confidence that any patient who requests assistance in hastening the end of his or her life does so as a matter of free choice.[11]

* * *

Recognition of a right to physician assistance in dying might well decrease those suicides that are of greatest legitimate concern to the State. Frank discussion of end-of-life issues between terminally ill patients, their treating physicians, and appropriate mental health professionals would necessarily raise the issues of capacity to make reasoned decisions, rationality, adequate information, exploration and availability of alternatives, and voluntariness discussed in this brief. Informed exploration of those issues might lead to the provision of appropriate treatment where all available methods have not been tried, and to the prevention of irrational and coerced deaths by those

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[11] With or without legal sanction, and with or without active or tacit professional assistance, some number of terminally ill patients already make their own decisions about exactly how and when to end their lives. One important effect of a decision affirming the judgments below might be to remedy an inequality akin to, but different from, that identified by the Second Circuit in *Quill*: the inequality between those patients who already have, whether through wealth, personal acquaintance, or mere physical ability, the de facto "right" to choose the time and manner of ending their battle with illness, and those whom disadvantage or disability consigns to live or die based solely on the medical and moral judgments of others. From the point of view of patient autonomy, surely it would be better to create a system under which some who have the power to die would receive the support or counseling that might convince them to live, while those who would truly choose to hasten their own ends would have the opportunity to do so without regard to fundamentally inconsequential criteria such as poverty or physical disability.

individuals who are not competent or rational (and whom the State has the greatest interest in protecting).

Similarly, because it is generally not legal to assist a patient to die, patients who wish to control their own deaths often reflect and act alone, without the benefit of counseling. They often believe that they must protect others by killing themselves in isolation, or earlier than they might otherwise choose, so they can be sure that they will still be able to carry out their own decision; or they may involve significant others, while feeling torn because doing so puts those individuals at risk both legally and emotionally. In either case, the results are often tragic. S. Jamison, *supra*, at 120-54; R. Ogden, *supra*, at 89-90. Drugs taken to hasten death, for instance, may not be properly absorbed, putting the patient at risk of further disability or prolonged suffering as a result of liver or kidney failure. Significant others may then be forced to become deeply involved. In desperation, they may even resort to violent measures, in which case the resulting post-traumatic stress compounds the tragedy. Holtby, *Social Work, Suicide, and Self Deliverance, in* 1 National Social Work AIDS Network Readings and Writings No. 3, 30 (1996). The availability of legal, regulated means for seeking assistance in dying, including the involvement of mental health professionals, would reduce these problems, and would allow professionals to deal openly with issues of emotional closure with a patient's family and helping the family to support the suffering individual. *See, e.g.*, Lester, *Easing the Legacy of Suicide: Counselor Assisted Suicide, in* Changes (forthcoming 1997); J. Werth, *supra*, at 100. Protection of the public would thus be enhanced, not diminished, by bringing physician assistance in dying under the scrutiny of the law.

The process of discussion and counseling that should accompany any end-of-life decision often does lead patients

to choose some option other than assisted suicide — even if the patient actively considers that course as one possibility. In fact, anecdotal reports and some recent research suggest that giving some patients a credible option, or even the means, to hasten death if they decide to do so in the future may decrease the patient's desire to die immediately, and even enhance the quality of the patient's remaining life, thus reducing the risk that a patient will act impulsively or prematurely. *See* Back et al., *Physician-Assisted Suicide and Euthanasia in Washington State: Patient Requests and Physician Responses*, 275 JAMA 919, 922 (1996); Block and Billings, *supra*, at 2045; *See* M. Battin, *The Death Debate-Ethical Issues in Suicide* 202 (1996), *quoting* C. Owens et al., *Cancer Patients' Attitudes to Final Events in Life: Wish for Death, Attitudes to Cessation of Treatment, Suicide and Euthanasia*, 3 Psycho-Oncology 1 (1994). It is worth emphasizing that the cases before this Court involve what is presently, and is likely to remain, a minority of patients who reach a carefully considered decision to hasten the end of life, even after a thorough exploration of the alternatives.

As mental health professionals, we have no interest in "promoting" assisted suicide. Our interest lies, instead, in the promotion of patient autonomy, balanced by concern for the welfare and protection of the public, and in the sound development of the law to that end.

CONCLUSION

The judgments of the courts of appeals should be affirmed.

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APPENDIX A

Coalition of Mental Health Professionals Supporting Individual Self-Determination in Decisions to Hasten Death

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APPENDIX B

National Association of Social Workers
Policy Statement

Client Self-determination in End-of-Life Decisions

BACKGROUND

End-of-Life decisions are the choices made by a person with a terminal condition regarding his or her continuing care or treatment options. These options may include aggressive treatment of the medical condition, life-sustaining treatment, palliative care, passive euthanasia, voluntary active euthanasia, or physician-assisted suicide. For the purposes of this policy statement, these terms are defined as follows:

Terminal and irreversible condition means a continual profound comatose state with no reasonable chance of recovery or a condition caused by injury, disease, or illness, which, within reasonable medical judgment, would produce death within a short time and for which the application of life-sustaining procedures would serve only to postpone the moment of death. There is no universally accepted definition of "a short time," but in general it is considered to be less than one year (American Hospital Association, 1991).

Client self-determination means the right of the client to determine the appropriate level, if any, of medical intervention and the right for clients to change their wishes about their treatment as their condition changes over time or during the course of their illness. Self-determination assumes that the client is mentally competent.

Incompetent means lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to any proposed treatment decision.

Advance health care directive is a document in which a person either states choices for medical treatment or designates who should make treatment choices if the person should lose decision-making capacity. Although the term "advance directive" generally refers to formal, written documents, it may also include oral statements by the patient (American Hospital Association, 1991).

Life-sustaining treatment is medical intervention administered to a patient that prolongs life and delays death (American Hospital Association, 1991).

Medically inappropriate life-sustaining procedures means life-sustaining procedures that are not in accord with the patient's wishes or that are medically futile.

Palliative care is medical intervention intended to alleviate suffering, discomfort, or dysfunction but not to cure (American Hospital Association, 1991).

Passive euthanasia is the withholding or withdrawing of life-sustaining treatment. It is the forgoing of treatment, sometimes called "letting die." The right-to-die rulings such as in the Karen Ann Quinlin case establish the right under certain circumstances to be disconnected from artificial life support.

Voluntary active euthanasia is a physician's administering a lethal dose after a clearly competent patient makes a fully voluntary and persistent request for aid in dying. This is the active termination of a patient's life by a physician at the request of the patient.

Physician-assisted suicide is a patient's ending his or her life with the means requested of and provided by a physician for that purpose. The physician and the patient are both involved. Nurses or significant others may also be involved, but the physician has the responsibility for

providing the means. In all cases, the patient will have been determined competent to make such a decision.

Some argue that little distinction exists between euthanasia and physician-assisted suicide other than mechanical or technical difference as to who—the patient or the physician—triggers the event. Others (for example, Quill, 1991) maintain the difference is significant in that in assisted suicide the final act is the patient's; the risk of subtle coercion from doctors, family, or other social forces is reduced; the balance of power between patient and physician is more equal; and there is less risk of error, coercion, or abuse.

There has been a proliferation of state legislation related to assisted suicide, including Washington State's "Death with Dignity" initiative, which was narrowly defeated in a referendum in 1991, and bills that were in progress in 1993 in the California, Iowa, Maine, Michigan, and New Hampshire state legislatures. (The Michigan bill required social work counseling to qualified applicants for assisted suicide.) Currently, 37 states outlaw actively helping a patient to die (Brody, 1992).

The Patients' Self-Determination Act of 1990, included in the Omnibus Budget Reconciliation Act of 1990, requires all hospitals participating in Medicare or Medicaid to ask all adult inpatients if they have advance directives, to document their answers, and to provide information on state laws and hospital policies. Other health agencies such as home health and hospice have instituted similar requirements (American Hospital Association, 1991). In many of these facilities, social workers are called on to work with patients regarding advance health care directives and end-of-life decisions.

ISSUE STATEMENT

Advances in medical capabilities and technology have made it possible to extend life through artificial means that were heretofore unimaginable. Although this level of care often provides enormous benefits for patients, it may also present difficult and increasingly complex ethical choices for patients, their families, and health care professional. Inappropriate or unwanted utilization of medical technology may lead to lessened quality of life, loss of dignity, and loss of integrity of patients.

State and federal legislation related to advance health care directives has raised public awareness about the right of patients to participate in medical decision making, including end-of-life decisions. The individuals most immediately facing end-of-life decisions are those with a terminal and irreversible condition, a progressive chronic illness, or chronic intractable pain.

As advocates for the rights of individuals; as providers of mental health services; and as workers in hospitals, hospices, nursing homes, and crisis centers, social workers regularly deal with quality-of-life issues and choices related to life and death. Social workers have requested guidelines that are compatible with professional and personal ethics, legal parameters, and respect for client self-determination. Furthermore, other professionals look to social work for guidelines on these complex issues:

> Social work values, our traditional role as advocates and enablers, and our self-awareness and conscious use of self should serve as justification for engaging people in open and honest debate, recognizing the biases that society and the health care system have had with respect to the backgrounds, lifestyles, and illness of different groups of patients . . . . The

> social work community has the opportunity and the obligation to educate, organize, and advocate for a more widespread and extensive debate of these life and death matters. (Mizrahi, 1992)

In acknowledging and affirming social work's commitment to respect diverse value systems in a pluralistic society, end-of-life issues are recognized as controversial because they reflect the varied value systems of different groups. Consequently, the National Association of Social Workers (NASW) does not take a position concerning the morality of end-of-life decisions, but affirms the right of the individual to determine the level of his or her care.

It is also recognized that de facto rationing of health care based on socioeconomic status, color, ability to pay, provider biases, and government policy differentially affects people's right to choose among viable service alternatives and their ability to give truly informed consent. The social worker should work to minimize the effect of these factors in determining the care options available to individuals:

In examining the social work role in working with clients around end-of-life decisions, the following issues must be addressed:

- the legal parameters that affect social work practice (for example, limits of confidentiality, state laws prohibiting assisted suicide, the potential for civil liability)
- the potential conflict of social work values with those of other health care professionals
- the emerging pressures for cost control and rationing of healthcare (for example, temptation of health care institutions and insurers to encourage use of end-of-life practices to control costs)

- the possibility of patients feeling obliged to choose death rather than becoming a burden (Brock, 1992)
- the societal limits on individual self-determination and autonomy
- the necessity to define safeguards to protect individual and society in the implementation of end-of-life practices

POLICY STATEMENT

NASW's position concerning end-of-life decisions is based on the principle of client self-determination. Choice should be intrinsic to all aspects of life and death.

The social work profession strives to enhance the quality of life; to encourage the exploration of life options; and to advocate for access to options, including providing all information to make appropriate choices.

Social workers have an important role in helping individuals identify the end-of-life options available to them. This role must be performed with full knowledge of and compliance with the law and in accordance with the *NASW Code of Ethics* (NASW, 1993). Social workers should be well informed about living wills, durable power of attorney for health care, and legislation related to advance health care directives.

A key value for social workers is client self-determination. Competent individuals should have the opportunity to make their own choices but only after being informed of all options and consequences. Choices should be made without coercion. Therefore, the appropriate role for social workers is to help patients express their thoughts and feelings, to facilitate exploration of alternatives, to provide information to make an informed choice, and to deal with grief and loss issues.

Social workers should not promote any particular means to end one's life but should be open to full discussion of the issues and care options. As a client is considering his or her choices the social worker should explore and help ameliorate any factors such as pain, depression, need for medical treatment, and so forth. Further, the social worker should thoroughly review all available options including, but not limited to, pain management, counseling, hospice, nursing home placement, and advance health care directives.

Social workers should act as liaisons with other health care professionals and help the patient and family communicate concerns and attitudes to the health care team to bring about the most responsible assistance possible.

Because end-of-life decisions have familial and social consequences, social workers should encourage the involvement of significant others, family, and friends in these decisions. social workers should provide ongoing support and be liaisons to families and support persons (for example, caregivers, significant others) with care to maintain the patient's confidentiality. When death occurs, social workers have an obligation to provide emotional and tangible assistance to the significant others, family, and friends in the bereavement process.

Social workers should be free to participate or not participate in assisted-suicide matters or other discussions concerning end-of-life decisions depending on their own beliefs, attitudes, and value systems. If a social worker is unable to help with decisions about assisted suicide or other end-of-life choices, he or she has a professional obligation to refer patients and their families to competent professionals who are available to address end-of-life issues.

It is inappropriate for social workers to deliver, supply, or personally participate in the commission of an act

of assisted suicide when acting in their professional role. Doing so may subject the social worker to criminal charges. If legally permissible, it is not inappropriate for a social worker to be present during an assisted suicide if the client requests the social worker's presence. The involvement of social workers in the assisted suicide cases should not depend on race or ethnicity, religion, age, gender, economic factors, sexual orientation, or disability.

NASW chapters should facilitate their membership's participation in local, state, and national committees, activities, and task forces concerning client self-determination and end-of-life decision. Education and research on these complex topics should be included in the social work role.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1996

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Petitioners,
v.
HAROLD GLUCKSBERG, M.D., *et al.*,
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On Writs of Certiorari to the United States Court of Appeals for the Ninth and Second Circuits

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BRIEF *AMICUS CURIAE* OF JULIAN M. WHITAKER, M.D. IN SUPPORT OF RESPONDENTS

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TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	ii
INTEREST OF THE *AMICUS CURIAE*	1
SUMMARY OF ARGUMENT	3
ARGUMENT	5
I. COMPETENT, TERMINALLY ILL PATIENTS HAVE A CONSTITUTIONAL LIBERTY RIGHT TO STOP THEIR SUFFERING THROUGH INGESTION OF LIFE-ENDING MEDICATIONS	5
A. Historic Antecedents to the Right to Bodily Integrity and to Control of One's Person	10
B. The Common Law Prohibition on Suicide Does Not Define "Liberty" and Is Anachronistic	16
II. THERE IS NO COMPELLING STATE INTEREST TO JUSTIFY VIOLATION OF THE LIBERTY RIGHT	19
A. For at Least 10% of the Terminally Ill Patients Adequate Pain Relief Is Not Possible	20
B. There Are Numerous Less Restrictive, Fully Adequate Alternatives to Proscription of the Right	22
CONCLUSION	23

TABLE OF AUTHORITIES

Cases: Page

Bowers v. Hardwick, 478 U.S. 186 (1986) 6, 8
Brown v. Board of Education, 347 U.S. 483 (1954) 7
Carey v. Population Services International, 431 U.S. 678 (1977) 8
Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990) 8, 9, 14, 16
Eisenstadt v. Baird, 405 U.S. 438 (1972) 8
Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1 (1979) 14
Griswold v. Connecticut, 381 U.S. 479 (1965) 6, 8
Ingraham v. Wright, 430 U.S. 651 (1977) 14
Jacobson v. Massachusetts, 197 U.S. 11 (1905) 9
Loving v. Virginia, 388 U.S. 1 (1967) 7, 8
Meyer v. Nebraska, 262 U.S. 390 (1923) 8
Michael H. v. Gerald D., 491 U.S. 110 (1989) 6
Moore v. East Cleveland, 431 U.S. 494 (1977) 6, 8
Mugler v. Kansas, 123 U.S. 623 (1987) 5
O'Connor v. Donaldson, 422 U.S. 563 (1975) 7
Olmstead v. United States, 277 U.S. 478 (1928) 11
Palko v. Connecticut, 302 U.S. 319 (1937) 6
Parham v. J.R., 442 U.S. 584 (1979) 16
Planned Parenthood v. Casey, 505 U.S. 833 (1992) ..... *passim*
Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976) 7
Pierce v. Society of Sisters, 268 U.S. 510 (1925) 8
Roe v. Wade, 410 U.S. 113 (1973) 7, 9
Rochin v. California, 342 U.S. 165 (1952) 3, 7, 9, 14
Sandin v. Conner, 115 S.Ct. 2293 (1995) 14
Shelton v. Tucker, 364 U.S. 479 (1960) 6
Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535 (1942) 4, 14
Snyder v. Massachusetts, 291 U.S. 97 (1934) 6, 19
Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 749 (1986) 8
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Whalen v. Roe, 429 U.S. 589 (1977) 8
Whitney v. California, 274 U.S. 357 (1927) 6
Youngberg v. Romero, 457 U.S. 307 (1982) 14

TABLE OF AUTHORITIES—Continued

Constitution, Statutes, and Regulations: Page

U.S. Const. amend. XIV ..... *passim*
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Miscellaneous:

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	Page
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Thomas J. Marzen, et al., *Suicide: A Constitutional Right? Reflections Eleven Years Later*, 35 Duq. L. Rev. 261 (1996)	16
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Susan S. Land & Richard B. Pratt, *You Don't Have to Suffer* (1994)	20
Sidney H. Wanzer, et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 New Eng. J. Med. 844 (1989)	4
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BRIEF *AMICUS CURIAE* OF JULIAN M. WHITAKER, M.D. IN SUPPORT OF RESPONDENTS

INTEREST OF THE *AMICUS CURIAE*

Amicus curiae, Julian M. Whitaker, M.D. ("Dr. Whitaker"), respectfully submits this brief in support of Respondents in *State of Washington v. Glucksberg*, No. 96-100, and *Vacco v. Quill*, No. 95-1858.[1]

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[1] Dr. Whitaker has received the written consent of the Petitioners and Respondents in both cases. Those letters of consent have been filed with the Clerk of the Court.

Dr. Whitaker is a physician licensed to practice medicine in the states of California and Washington.[2] He is the Clinical Director of The Whitaker Wellness Institute in Newport Beach, California and the editor of *Health & Healing*, the nation's largest single editor health newsletter with approximately 500,000 subscribers.[3]

Many of those whom Dr. Whitaker treats are geriatric patients who suffer from chronic and debilitating illnesses. A minority of those patients are terminally ill in the latter stages of disease. Of those, a few suffer from severe and persistent pain despite the administration of higher dosage levels of appropriate pain relieving drugs. For them, a stark question inevitably arises: Are the moments of consciousness accompanied by severe and persistent pain worth enduring if no cure is possible and if time brings with it only more pain, greater need for pain medication, side effects from that medication, new kinds of pain from the progression of the disease, less freedom and personal dignity, and greater incapacity? Each person in this category will answer that question differently. Answers depend on each person's deeply held personal values and beliefs, unique life expereince, and unique tolerance for pain. Some will choose to endure until the disease conquers life by robbing every vital sign. Others will choose to end their agony by either (1) discontinuing life-sustaining treatment, (2) consuming lethal doses of pain killing medication, or (3) consuming other drugs that have the effect of ending life. Your *amicus* believes it neither morally appropriate nor consistent with this Court's prece-

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[2] Dr. Whitaker graduated from Dartmouth College in 1966 with a B.S. degree and Emory University in 1970 with an M.D. degree. He received his formal training in surgery as a resident at the University of California Medical School and in medicine as a physician with the Pritikin Institute in California.

[3] Dr. Whitaker is the author of five books on age-related diseases: *Reversing Heart Disease* (1985), *Reversing Diabetes* (1987), *Reversing Health Risk* (1989), *Natural Healing* (1994), and *What Your Doctor Won't Tell You About Bypass* (1995).

dent for the Government to deny competent, terminally ill patients freedom to elect a humane, dignified, and prompt departure from life rather than an extended dying process robbed of value and dignity by severe pain and incapacity.

To be sure, consistent with this Court's precedent, the state retains the power to regulate the conditions under which those choices are exercised. The state cannot, consistent with the precedent protecting "bodily integrity" and "control" over "one's person," deny the choice altogether. In those rare and horrible circumstances when a competent patient's terminal illness is accompanied by severe, unrelenting pain for which relief is not possible,[4] that patient has a constitutional liberty right to maintain bodily integrity and personal control by ending life and avoiding further agony and indignity. It offends the core meaning of Fourteenth Amendment liberty for the state to force a patient to endure ever greater pain and incapacity until death results.

SUMMARY OF ARGUMENT

The Court has long recognized a right to "bodily integrity," a right to "control [of] one's person." *See, e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 915 (1992) (Stevens J., concurring in part and dissenting in part) (citing *Rochin v. California*, 342 U.S. 165 (1952), and

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[4] *See* American Medical Ass'n Council on Scientific Affairs, *Good Care of the Dying Patient*, 275 J.A.M.A. 474, 475 (1996):

> How commonly pain marks the actual experience of dying is uncertain, and estimates vary substantially across institutions, whether hospices or hospitals. Coyle et al reported that three of every four cancer patients have pain. Bonica's review of published reports indicates that more than half of cancer patients have severe pain. Saunders has claimed that one fourth of cancer patients have inadequate pain control when dying.

See also C.S. Cleeland, et al., *Pain and its Treatment in Out-patients with Metastic Cancer*, 330 New Eng. J. Med. 592 (1994).

Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535 (1942)). In these consolidated cases, the Court will decide whether that personal right is possessed by competent, terminally ill patients who elect to stop their pain and suffering by consuming life-ending medications. The Court will also decide whether there is any meaningful difference between death effected by a physician's cessation of life support and a physician's administration of palliative treatments,[5] on the one hand, and death effected by a physician's provision or prescription of life-ending medications, on the other.

Your *amicus* asserts that the right to bodily integrity, to control of one's person, protects the election of a competent, terminally ill person to stop his or her suffering through the ingestion of life-ending medications. Your *amicus* finds no principled basis for distinguishing between (i) cessation of life support, a legal alternative; (ii) administration of palliative treatments in doses known to be lethal, a legal alternative;[6] and (iii) provision or prescription of other life-ending medications, an alternative unlawful under the statutes here in issue. Any physician who would fulfill a patient's request for any one of the three modes of hastening death understands the probable outcome: death. By forbidding the third alternative, New York and Washington do not end physician-assisted suicide. Instead, they deny competent, terminally ill patients who wish to hasten death an essential option, one that avoids acts of self-inflicted violence, avoids a slow and painful demise through refusal of life-support, which causes starvation or suffocation, and avoids the incursion of pain at ever higher thresholds until an overdose of pain medication is prescribed. By forbidding the option of physician-assisted suicide through provision or prescription of life-ending medication, New York and Washington deny the competent, terminally ill patient control over his or her bodily integrity. That denial renders each such person a prisoner of legal procedure, forced to endure pain and suffering beyond a threshold that he or she can tolerate. Your *amicus*, therefore, urges the Court to uphold the decisions below and to recognize the existence of a constitutional liberty right of the competent, terminally ill to end their pain and suffering through ingestion of life-ending medications.

[5] *See* Courtney S. Campbell, *Suffering, Compassion, and Dignity in Dying*, 35 Duq. L. Rev. 109, 112 (1996) ("It is common knowledge . . . that palliative care for pain and suffering tends to significantly diminish the number of patient requests for a hastened and assisted death") (citing Sidney H. Wanzer, et al., *The Physician's Responsibility Toward Hopelessly Ill Patients: A Second Look*, 320 New Eng. J. Med. 844, 846-48 (1989)).

[6] Physician administration of pain relieving medications is considered lawful even if death results from overdosing. *See* George J. Annas, *Death by Prescription—The Oregon Initiative*, 331 New Eng. J. Med. 1240 (1994); Norman Contor, et al., *Pain Relief, Acceleration of Death, and Criminal Law*, 6 Kennedy Inst. Ethics J. 107 (1996). *See also* Thomas A. Preston, *Killing Pain, Ending Life*, N.Y. Times, Nov. 1, 1994, at A15.

ARGUMENT

I. COMPETENT, TERMINALLY ILL PATIENTS HAVE A CONSTITUTIONAL LIBERTY RIGHT TO STOP THEIR SUFFERING THROUGH INGESTION OF LIFE-ENDING MEDICATIONS

There are few principles more embedded in our constitutional law than that "liberty" within the Due Process Clause of the Fourteenth Amendment ~~that have~~ has substantive as well as procedural meaning.[7] The Court has held that a

[7] As the Court explained in *Planned Parenthood v. Casey*, 505 U.S. 833, 846-847 (1992):

> Although a literal reading of the Clause might suggest that it governs only the procedures by which a State may deprive persons of liberty, for at least 105 years, since *Mugler v. Kansas*, 123 U.S. 623, 660-661 . . . (1987), the Clause has been understood to contain a substantive component as well . . . As Justice Brandeis (joined by Justice Holmes) observed, "[d]espite arguments to the contrary which had seemed to me persuasive, it is settled that the due process clause of the Fourteenth Amendment applies to matters of substantive law as well as to matters of procedure. Thus all fundamental rights comprised within the term liberty are protected by the Federal

liberty interest will be protected if it is "fundamental." A fundamental liberty interest is one "implicit in the concept of ordered liberty" such that "neither liberty nor justice would exist if [it] were sacrificed," *Palko v. Connecticut*, 302 U.S. 319, 325, 326 (1937); "so rooted in the traditions and conscience of our people as to be ranked as fundamental," *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934) (*see also Michael H. v. Gerald D.*, 491 U.S. 110, 122 (1989) (citing *Snyder*)); or "deeply rooted in this Nation's history and tradition," *Moore v. East Cleveland*, 431 U.S. 494, 503 (1977). Direct burdens upon fundamental liberty interests are impermissible unless "the governmental entity imposing the restriction can demonstrate that the limitation is both necessary and narrowly tailored to serve a compelling governmental interest." *Planned Parenthood v. Casey*, 505 U.S. 833, 929 (1992) (citing *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965)). Such burdens will not withstand scrutiny if less drastic means exist for achieving the government's purpose. *See, e.g., Shelton v. Tucker*, 364 U.S. 479, 488 (1960).

Although the Court cannot disregard a "relevant tradition protecting, or denying protection to, the asserted right," *Michael H. v. Gerald D.*, 491 U.S. 110, 127 (1989), neither can it apply historical precedent mechanistically because in times past right violations have in fact become

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Constitution from invasion by the States" [citing *Whitney v. California*, 274 U.S. 357, 373 (1927)].

See also Bowers v. Hardwick, 478 U.S. 186, 191 (1986):

> It is true that despite the language of the Due Process Clauses of the Fifth and Fourteenth Amendments, which appears to focus only on the processes by which life, liberty, or property is taken, the cases are legion in which those clauses have been interpreted to have substantive content, subsuming rights that to a great extent are immune from federal or state regulation or proscription. Among such cases are those recognizing rights that have little or no textual support in the constitutional language. *Meyer*, *Prince*, and *Pierce* fall into this category, as do the privacy cases from *Griswold* to *Casey*.

deeply rooted in our nation's history and condoned by a majority. *See, e.g., Loving v. Virginia*, 388 U.S. 1 (1967) (invalidating a law prohibiting miscegenation despite a long history of public acceptance); *Roe v. Wade*, 410 U.S. 113 (1973) (invalidating abortion proscription despite the fact that abortion was an illegal act at common law); *Brown v. Board of Education*, 347 U.S. 483 (1954) (invalidating racial segregation in schooling despite a long history of public and legal acceptance of that practice); and *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 69 (1976) (rejecting requirement of husband's consent for married women to obtain abortion despite common law limitations on women's legal rights and status).[8] Moreover, advances in technology can affect the scope of a liberty interest and, indeed, what is and what is not protected by the Due Process Clause.[9]

In defining the meaning of "liberty," the Court implores caution. It proceeds with due regard for precedents that define the scope of liberty already protected by the Constitution, because "[t]he Court is most vulnerable and

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[8] *See also O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975) ("[m]ere public intolerance or animosity cannot constitutionally justify the deprivation of a person's physical liberty") and *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 749, 789 (1986) (White, J., dissenting):

> The Constitution is not a deed setting forth the precise metes and bounds of its subject matter; rather, it is a document announcing fundamental principles in value-laden terms that leave ample scope for the exercise of normative judgment by those charged with interpreting and applying it. In particular, the Due Process Clause of the Fourteenth Amendment, which forbids the deprivation of 'life, liberty, or property without due process of law,' has been read by the majority of the Court to be broad enough to provide substantive protection against state infringement of a broad range of individual interests.

[9] *See Rochin v. California*, 342 U.S. 165, 171-172 (1952) ("To believe that this judicial exercise of judgment could be avoided by freezing 'due process of law' at some fixed stage of time or thought is to suggest that the most important aspect of constitutional adjudication is a function for inanimate machines and not for judges").

comes nearest to illegitimacy when it deals with judge-made constitutional law having little or no cognizable roots in the language or design of the Constitution." *Bowers v. Hardwick*, 478 U.S. 186, 194 (1986).

In that regard, this Court has long recognized that the liberty right protects individual, life-affecting elections of the most personal nature: "Our cases have long recognized that the Constitution embodies a promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government." *Thornburgh v. American College of Obstetricians & Gynecologists*, 476 U.S. 747, 772 (1986), *citing Carey v. Population Services International*, 431 U.S. 678 (1977); *Moore v. East Cleveland*, 431 U.S. 494 (1977); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Pierce v. Society of Sisters*, 268 U.S. 510 (1925); *Meyer v. Nebraska*, 262 U.S. 390 (1923); and *Whalen v. Roe*, 429 U.S. 589, 598-600 (1977). For example, this Court has recognized as fundamental and, so, beyond the government's reach, the right to bear or beget a child, *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972); to establish a home and raise children, *Meyer v. Nebraska*, 262 U.S. 390, 399 (1923); to marry, *Loving v. Virginia*, 388 U.S. 1 (1967); to procreate, *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942); to use contraceptives, *Griswold v. Connecticut*, 381 U.S. 479 (1965); to direct the upbringing and education of a child, *Pierce v. Society of Sisters*, 268 U.S. 510, 534-535 (1925); to decide independently, with the advice of a physician, to acquire and to use needed medication, *Whalen v. Roe*, 429 U.S. 589, 603 (1977); to avoid unwanted administration of antipsychotic drugs, *Washington v. Harper*, 494 U.S. 210, 221-222 (1990); and to refuse unwanted medical treatment, *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 281 (1990). In each of these cases, the Court has protected "personal autonomy" from government deprivation. *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 791 (1986) (White, J., dissenting).

In *Planned Parenthood v. Casey*, 505 U.S. 833, 847 (1992), reflecting upon this precedent, the Court wrote of a "realm of personal liberty which the government may not enter" that involves "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy." *Id.* at 851. The Court found such choices to be "central to personal dignity and autonomy" and "central to the liberty protected by the Fourteenth Amendment." *Id.* Indeed, the Court explained that "the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." *Id.*

Constitutional liberty, this Court has already concluded, embraces personal, life-affecting decisions, such as the decision to abort a fetus or to refuse medical treatment:

> *Roe* [*v. Wade*] . . . may be seen not only as an exemplar of *Griswold* liberty but as a rule (whether or not mistaken) of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection. If so, our cases since *Roe* accord with *Roe*'s view that a State's interest in the protection of life falls short of justifying any plenary override of individual liberty claims. *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990) . . . . see also, *e.g.*, *Rochin v. California*, 342 U.S. 165 (1952) . . . *Jacobson v. Massachusetts*, 197 U.S. 11, 24-30 . . . (1905).

Planned Parenthood v. Casey, 505 U.S. at 857.

Because "liberty" encompasses personal, life-affecting decisions such as whether to abort a fetus, to refuse unwanted drugs, or to refuse unwanted medical treatment necessary to sustain life, it would be illogical, and a radical departure from precedent, to hold that it does not also protect a competent, terminally ill patient's election to forego further suffering by ingesting a life-ending med-

ication. The Court's personal liberty rationale for protecting the right to abort and the right to refuse treatment applies with equal validity to a competent, terminally ill person's election to ingest life-ending medication.

In most instances, the constitutionally protected refusal of hydration, feeding, and artificial respiration brings on a slow, agonizing death: starvation or suffocation. The practice of escalating pain medication until death results (also widely condoned by law) is another slow and painful approach. The methods are, however, indistinguishable in ultimate effect from the provision or prescription of life-ending medication. It would therefore offend this Court's precedent, and basic logic, to deny constitutional protection for physician-assisted suicide in the case of competent, terminally ill persons.

A. Historic Antecedents to the Right to Bodily Integrity and to Control of One's Person

The understanding of "liberty" that originally animated the Fifth Amendment, and later came to be the core understanding of the Fourteenth Amendment, arose in the seventeenth and eighteenth centuries with the opposition political movement to the Hanoverian Kings (the so-called "Radical Whigs") and held sway in the colonies and with the original founders.[10] The revolutionary legislators

[10] *See* Bernard Bailyn, 1 Pamphlets of the American Revolution *1750-1776* 28-29 (1965); Steven J. Heyman, *The First Duty of Government: Protection Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 516 (1991) (. . . a small group of radical Whig opposition writers . . . had a crucial impact on the development of American political thought in the decades leading up to the Revolution"). Two Radical Whigs, Thomas Gordon and John Trenchard, were most notable in the American colonies for their collection of 138 essays on civil and religious liberty that were published in book form and entitled *Cato's Letters*. First published serially in *The London Journal* from 1720 to 1723, the essays were republished as books and went through six editions between 1723 and 1755. Historian Bernard Bailyn writes:

> Republished entire or in part again and again in the colonies, "quoted in every colonial newspaper from Boston to Savannah," and referred to repeatedly in the pamphlet literature, the writings of Trenchard and Gordon ranked in the minds of the Americans with treatises of Locke as the most authoritative statement of the nature of political liberty and above Locke as an exposition of the social sources of the threats it faced.

Bernard Bailyn, 1 *Pamphlets of the American Revolution 1750-1776* 30 (1965). Historian Forrest McDonald notes that *Cato's Letters* were "widely read by American patriots." F. McDonald, *Novus Ordo Seclorum* 47 (1985). Historian Jeffrey Smith finds that *Cato's Letters* "were immensely popular in America, where journalists and political theorists praised and imitated the authors." Jeffrey Smith, *Printers and Press Freedom* 25 (1988).

of the newly formed states gave legal force to these conceptions of liberty by rendering them among the "inalienable" rights protected under the original state constitutions.[11]

As for the meaning of "liberty" pertinent to medical treatment, the Radical Whigs Trenchard and Gordon defined the term in words similar to those later chosen by Justice Brandeis.[12] Gordon and Trenchard believed liberty a right "to live upon one's own terms."[13] With particular pertinence to government regulation of suicide, Trenchard and Gordon wrote:

> But whilst Men have their five Senses, I cannot see what the Magistrate has to do with Actions by which the Society cannot be affected; and where he meddles with such, he meddles impertinently or tyrannically. Must the Magistrate tie up every Man's Legs, because some Men fall into Ditches? . . . . Or, would it become the Wisdom and Care of Governors to establish a travelling [sic] Society, to prevent People, by

[11] *See* ROBERT RUTLAND, *The Birth of the Bill of Rights, 1776-1791* 42 (1983).

[12] Justice Brandeis considered the "liberty" right a "right to be let alone." *Olmstead v. United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting).

[13] 1 *CATO's Letters* 249 (L. Levy ed., Reprint 1971).

> proper Confinement, from throwing themselves into Wells, or over Precipices; Or to endow a Fraternity of Physicians and Surgeons all over the Nation, to take Care of their Subjects Health, without being consulted; and to vomit, bleed, purge, and scarify [sic] them at Pleasure, whether they would or no, just as these established Judges of Health should think fit? If this were the Case, what a Stir and Hubbub should we soon see kept about the established Potions and Lancets . . . Let People alone, and they will take Care of themselves, and do it best . . .

1 *CATO's Letters* 247 (L. Levy, ed. 1971).

Thus, strong conceptions of personal autonomy and freedom from restraint (even restraint against suicide) were deeply rooted in our historic understanding of "liberty"—a legacy of the eighteenth century Radical Whigs. Additional meaning for the term "liberty" came from Coke, Blackstone, and Locke but "[w]hat integrated all these sources into a coherent world view for Americans, as Bernard Bailyn and Gordon Wood have shown, was radical Whig ideology." [14]

Coincidental with the popular and political definitions of "liberty" communicated by the Radical Whigs were the eighteenth and nineteenth century legal understandings of the term derived from Chapter 29 of the Magna Carta.[15] In his *Commentaries on the Laws of England*, William Blackstone defined certain liberty rights as "abso-

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[14] *See* Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 521 (1991).

[15] Chapter 29 of the Magna Carta provides: "No freeman shall be taken, or imprisoned, or be disseised of his Freehold, or Liberties, or free Customs, or be outlawed, or exiled, or any otherwise destroyed; nor will [the sovereign] pass upon him, nor condemn him, but by lawful Judgment of his Peers, or by the Law of the Land." Magna Carta ch. 29 (1225) (Eng.), 1 Stat. at Large 7-8 (London, 1763).

lute" and others as "relative." [16] The absolute rights included those to "personal security, personal liberty, and private property." [17] "Personal security" included "a person's legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation." [18] "Personal liberty" included freedom of movement "without imprisonment or restraint, unless by due course of law." [19] "Private property" included "the free use, enjoyment, and disposal of all [one's] acquisitions, without any control or diminution, save only by the laws of the land." [20]

In America, the rights to "personal security, personal liberty, and private property" became those to "life, liberty, and property" but carried much of the Blackstonian meaning. The protection of those rights for all Americans regardless of race was a principal aim of the Fourteenth Amendment.[21] As this Court has recognized repeat-

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[16] "Absolute rights were those that would belong to individuals in a state of nature. By contrast, relative rights were those that were 'incident to [persons] as members of society, and standing in various relations to each other.'" The "first and primary end of human laws' was 'to protect individuals in the enjoyment of [their] absolute rights'; the protection of relative rights was a secondary aim." Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 532 (1991) (quoting William Blackstone, 1 *Commentaries on the Laws of England* 123-124; 134; 422 (St. George Tucker ed., 1803 & photo reprint 1969)).

[17] William Blackstone, 1 *Commentaries on the Laws of England* 129 (St. George Tucker ed., 1803 & Photo reprint 1969); James Kent, 2 *Commentaries on American Law* 1-37 (1826); Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507, 532 (1991).

[18] William Blackstone, *Commentaries on the Laws of England* 129 (St. George Tucker ed., 1803 & photo reprint 1969).

[19] *Id.* at 134.

[20] *Id.* at 138.

[21] *See* Steven J. Heyman, *The First Duty of Government: Protection, Liberty and the Fourteenth Amendment*, 41 Duke L. J. 507,

edly, the liberty right protected by the Fourteenth Amendment includes, at its core, the Blackstonian rights to personal security and personal liberty.[22]

The Court's recognition of a right to "bodily integrity" and "to control" of "one's person"[23] is in complete accord with the core meaning of the liberty right: the Blackstonian meaning (its barrier to state deprivation of "personal security" (*i.e.*, personal control over one's life, limbs, body, and health) and of "personal liberty" (*i.e.*, freedom from restraint)). So too is the Court's decision in *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 278 (1990) that "a competent person has a constitu-

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546-570 (1991). "[A]s the congressional debates indicate, when the Framers referred to 'life, liberty [and] property,' they principally mean the *rights* to life, liberty and property. They identified these rights with 'the absolute rights' of individuals recognized in the classical legal tradition: the rights to personal security, personal liberty, and private property." *Id.* at 561-562.

[22] *See Ingraham v. Wright*, 430 U.S. 651, 673-674 (1977) ("While the contours of this historic liberty interest in the context of our federal system of government have not been defined precisely, they always have been thought to encompass freedom from bodily restraint and punishment [citing *Rochin v. California*, 342 U.S. 165 (1952)]"); *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982) ("In the past, this Court has noted that the right to personal security constitutes a 'historic liberty interest' protected substantively by the Due Process Clause [citing *Ingraham v. Wright*, 430 U.S. 651, 673 (1977)]"; *Greenholtz v. Nebraska Penal Inmates*, 442 U.S. 1, 18 (1979) (Powell, J., concurring in part and dissenting in part) ("Liberty from bodily restraints always has been recognized as the core of the liberty protected by the Due Process from arbitrary government action"); and *Sandin v. Conner*, 115 S.Ct. 2293, 2307 (1995) (Breyer, J., dissenting) ("In protecting liberty . . . the Due Process Clause protects . . . an absence of government restraint, the very absence of restraint that we call freedom").

[23] *Planned Parenthood v. Casey*, 505 U.S. 833, 915 (1992) (Stevens, J., concurring in part and dissenting in part) (citing *Rochin v. California*, 342 U.S. 165 (1952), and *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 585 (1942)).

tionally protected liberty interest in refusing unwanted medical treatment . . ."

The petitioners and certain of their *amici* call on the Court to sever from the right to bodily integrity an essential exercise of that right. On the one hand, petitioners laud protection of a terminal patient's election to end artificial life support but, on the other, they condemn protection of a terminally ill patient's election to ingest a life-ending medication. Their position is untenable in law and logic.

In both cases, it is the patient's desire to die and it is the physician's action that initiates a causal chain of events that logically results in death. In neither case, does "nature" take its course because there have been substantial artificial interventions: (1) the use of medical devices to infuse the body with life through artificial respiration, nourishment, and hydration and (2) the chronic use of cytotoxic drugs or pain killing medications to mask the very cruel "nature" of a cancer or other painful and terminal illness.

There is no principled distinction to be drawn between the two cases. The critical issue in both is whether the state has imposed a restraint upon bodily integrity that denies a terminally ill patient control over his or her person. A constraint that precludes a person's physician from ceasing life support to comply with a patient's wishes is of no material difference from one that precludes a person's physician from providing or prescribing a lethal dose of pain medication or a lethal dose of life-ending medication. In each case the liberty interest consists of the right to effectuate the terminally ill patient's desires to end suffering by hastening death. In each case, when the state intrudes to preclude effectuation of that desire, it invades the patient's bodily integrity, robs the patient of control over his or her person, and imposes its

command that the patient live in pain and incapacity on one who would rather end the ordeal.[24]

As Justice O'Connor presciently observed in *Cruzan*:

> A seriously ill or dying patient whose wishes are not honored may feel a captive of the machinery required for life-sustaining measures or other medical interventions. Such forced treatment may burden that individual's liberty interests as much as any state coercion [citing *Washington v. Harper*, 494 U.S. 210, 221 (1990) and *Parham v. J.R.*, 442 U.S. 584, 600 (1979)].

497 U.S. at 288 (O'Connor, J., concurring).

B. The Common Law Prohibition on Suicide Does Not Define "Liberty" and Is Anachronistic

The petitioners and some of their *amici* contend that the Court should not recognize a constitutional right to physician-assisted suicide because at common law in pre-revolutionary America suicide was unlawful.[25] The conclusion reached, however, does not follow, and petitioners' reliance upon the common law suicide prohibition is misplaced. The Fourteenth Amendment's "liberty" term has never before been defined with reference to physician-assisted suicide. In addition, the world view that originally led to a general condemnation of suicide was predicated on a mystical conception of illness, dying, and death that has since been supplanted by a modern scientific view and understanding of those conditions. If the Court ties "liberty" to the pre-revolutionary view, it will cause the Four-

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[24] *See generally* Sanford Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 Calif. L. Rev. 857, 864, 868 (1992).

[25] *See generally* Thomas J. Marzen, et al., *Suicide: A Constitutional Right?*" 24 DUQ. L. REV. (1985); *Suicide: A Constitutional Right?—Reflections Eleven Years Later*, 35 Duq. L. Rev. 261 (1996).

teenth Amendment to become an anachronism rather than a vital force capable of transcending the ages.[26]

Even if the history of the common law in pre-revolutionary America is credited as evidence of the meaning of "liberty" within the Fourteenth Amendment, the eighteenth century ban on all suicides is anachronistic. People of the eighteenth century could not discern whether illness was terminal, nor did they have any understanding of microbiology. Disease, dying, and death were shrouded in mystery. Disease, dying, and death were frequently attributed to acts of God or Satan.[27] In short, while in eighteenth century America the onset of illness and the

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[26] Oliver W. Holmes, *The Path of the Law*, 10 Harv. L. Rev. 457, 469 (1897): "It is revolting to have no better reason for a rule of law than that it was laid down in the time of Henry IV. It is still more revolting if the grounds upon which it was laid down have vanished long since, and the rule simply persists from blind imitation of the past."

[27] The patient of the eighteenth century lived in an age when medicine was in its infancy (not until the late nineteenth century did microbiology reveal a previously invisible world of pathological agents). *See* 1 COMPANION ENCYCLOPEDIA OF THE HISTORY OF MEDICINE 65 (W.F. Bynum & R. Porter, ed. 1993). Medicine of the eighteenth century could not accurately diagnose disease, relied heavily upon frequent "bleedings" and "purgings" to rid the body of "evil humors," rarely discerned the presence of terminal illness, could not inform the patient with any degree of confidence of the nature or extent of pain associated with disease progression, and could not predict within reason the likely time of the patient's demise. *See Id.* at 320 ("[I]n the eighteenth century sickness remained a mysterious and unavoidable event resulting from fate or divine retribution"; "[m]inisters and priests continued to participate in . . . folk-healing schemes, a fact attested to by *Primitive Physick*, a widely circulated health manual by the Methodist John Wesley (1703-91)"; and "[t]he disease process was still most commonly explained in terms of a febrile crisis within the body, involving a 'coction' of peccant matter, resolved by excretion of this matter through the body's pores or orifices"). There was no scientific way to adjudge the quality of life or longevity.

arrival of death were simply not understood (the people of the time believed mystical external forces governed fate and should not be tampered with by mortal man), in twentieth century America the onset of illness and the arrival of death are generally understood. Indeed, unlike in the eighteenth century, it is now possible to segregate from the universe of all diseases a specific and limited class of illness that remains incurable. We now know scientifically the diseases drugs can treat successfully and those they cannot. We can also generally predict the time and nature of death for the terminally ill.[28] Many of the mysteries surrounding disease, dying, and death are gone. To a far greater extent than ever before, modern medical technology influences each of the processes of life and dying. We live into our sixties, seventies, and eighties through artificial interventions, including xenobiotic drugs and medical devices, and we die when those interventions no longer succeed in stemming the onslaught of ever persistent disease.

Hence, a general public condemnation of suicide in a society where life and death were believed to be commanded by mystical and religious forces cannot reasonably support argument for a specific condemnation of the provision of prescription of life-ending medication in our time. Lacking a direct casual connection between the prerevolutionary common law condemnation of suicide and the meaning of the Fourteenth Amendment's "liberty"

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[28] For example, the Medicare hospice benefit is limited to persons whose physicians attest that the patient has "a terminal illness with a life expectancy of six months or less." Health Care Finance Administration, *Medicare Part B Reference Manual*, Revision 020, (Aug. 23, 1996). Only 15% of patients receiving hospice care under Medicare Part B are alive for six months or more; the median survival time is approximately thirty-six days. Nicholas Christakis, et al., *Survival of Medicare Patients After Enrollment in Hospice Programs*, 335 New Eng. J. Med. 172-178 (1996).

term, this Court has no proper foundation for construing the Fourteenth Amendment's "liberty" term to prohibit a competent, terminally ill patient's election to ingest life-ending medications. Instead, as it has done repeatedly in the past, the Court should look to the meaning intended for the "liberty" term in Anglo-American history before the adoption of the Fifth and Fourteenth Amendments (a meaning that embraces protection for "bodily integrity" and "control" of "one's person").

Unlike the restrictive definition urged upon the Court by the petitioners, the more enlightened definition gleaned from the history underlying the Fifth and Fourteenth Amendments has the benefit of being both "rooted in the traditions and conscience of our people," *Snyder v. Massachusetts*, 291 U.S. at 105, and "implicit in the concept of ordered liberty" as defined by this Court's precedent.

II. THERE IS NO COMPELLING STATE INTEREST TO JUSTIFY VIOLATION OF THE LIBERTY RIGHT

Certain *amici* supporting the petitioners have argued that life in the final days of existence with a terminal illness can be rendered bearable through the administration of pain killing medication. They argue that patients informed of means to treat pain are usually persuaded to forego hastening death. Moreover, they argue that cancer patients contemplating physician-assisted suicide may be victimized by relatives who seek an inheritance or physicians more concerned with conserving medical resources than tending to the needs of a dying person.

In fact, for a significant minority of the terminally ill, adequate pain relief is not possible. Furthermore, untoward influences from physicians and family members, albeit a genuine concern, are matters ripe for tailored state regulation. There is no reason to conclude that the less restrictive alternative of tailored state regulation (such as mandatory second opinions and psychiatric evaluations)

would be an inadequate alternative to proscription of the right.

A. For at Least 10% of Terminally Ill Patients Adequate Pain Relief Is Not Possible

It is indeed true that in the vast majority of cases the terminally ill can cope with their pain through most, if not all, stages of disease progression if appropriate palliative treatments are administered. But even optimistic estimates on the success of pain management admit that at least 10% of terminally ill patients suffer from uncontrollable pain.[29] It is for them that palliative treatments afford inadequate relief.[30]

Patients with cancer often have multiple pain problems. Cancer pain may be due to (1) tumor progression and related pathology (e.g., nerve damage), (2) operations and other invasive diagnostic or therapeutic procedures, (3) toxicities of chemotherapy and radiation, (4) infection, or (5) muscle aches when patients limit physical activity. The incidence of pain in patients with cancer depends on the type and stage of disease. At the time of diagnosis and at intermediate stages, 30 to 45 percent of patients experience moderate to severe pain. On average, nearly 75 percent of patients with advanced cancer have pain. Of cancer patients with pain, 40 to 50 percent report

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[29] *See, e.g.*, Susan S. Land & Richard B. Patt, *You Don't Have to Suffer* 67 (1994):

> A concerned and knowledgeable doctor, from any specialty, can help up to 90 percent of patients achieve good control of pain. This process can be time consuming through no fault of his .... The key is to accept in advance that rarely can a doctor get it right the first time.

[30] Perhaps in time research will offer a cure for the currently incurable diseases or a means to alleviate intractable pain in all cases. Until that time, however, a significant minority of terminally ill patients will continue to need an alternative to the escalation of pain and incapacity that precedes their demise.

it as moderate to severe, and another 25 to 30 percent describe it as very severe.[31]

There is a wide spectrum in pain types.[32] The level, degree, and nature of pain varies depending on the terminal illness. Dr. Kathleen Foley's research led her to conclude that 85% of patients with primary bone tumors, 52% of patients with breast cancer, 20% of patients with lymphoma, and 5% of patients with leukemia had pain, She also found that 78% of hospitalized cancer patients had pain due directly to tumor involvement, 50% had pain due to bone disease, 25% had pain due to nerve compression, and 19% had pain due to the treatments they were given.[33]

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[31] *See* Kathleen M. Foley, *Pain Sydromes in Patients With Cancer* (1978); C.S. Cleeland, et al., *The Prevalence and Severity of Pain in Cancer*, 50 CANCER 1913-1918 (1982); J. Bonica, 1 *Cancer Pain —The Management of Pain* 400-460 (2d ed., 1990).

[32] *See* Kathleen M. Foley, *The Treatment of Cancer Pain*, 313 New Eng. J. Med. 85 (1985).

[33] *See* Kathleen M. Foley, *The Treatment of Cancer Pain*, 313 New Eng. J. Med. 85-86 (1985). Dr. Foley identifies two general categories of pain: acute and chronic. Acute pain is associated with hyperactivity of the autonomic nervious system. Acute pain is subcategorized into pain that is cancer-related (*i.e.*, pain that gives rise to the initial cancer diagnosis) and pain that is treatment-related (*i.e.*, pain occurring after administration of cytotoxic chemotherapy drugs and radiation therapy). Chronic pain is defined as pain that persists longer than 6 months in which adaptation of the autonomic nervous system occurs. Chronic pain transforms the person by permanently impairing their functional ability, altering their personalities, and affecting their lifestyles. Chronic pain is subcategorized into those that are cancer-related, involving pain arising from progression of the disease, and pain that is independent from and pre-exists the cancer. Foley identifies a subgroup consisting of those whose acute or chronic pain is accompanied by preexisting chronic pain unrelated to their cancer and a subgroup consisting of patients with a history of drug addition and cancer-related pain for which palliative treatment is rendered exceedingly complex because of the need to control the addiction. Foley's fifth

While palliative treatments can eliminate pain in a substantial number of cancer and AIDS cases, there remain those for whom such treatments are inadequate. It is precisely those patients whose rights must be protected should they elect to ingest life-ending medications rather than fight an unwinnable battle.

B. There Are Numerous Less Restrictive and Fully Adequate Alternatives to Proscription of the Right

There can be no doubt that from time to time certain individuals possessed of malicious intent (whether family members, friends, or physicians) will exert an untoward influence on the terminally ill, urging them to make a decision for or against physician-assisted suicide that may not be the one the patient would make if fully possessed of independent reason. That problem, and, indeed, any other abuse of the right, can be remedied by tailored state regulation (*i.e.*, regulation having only an incidental effect on the exercise of the right). An argument that presupposes abuse of a right as a justification for suppressing it is a classic fallacy of logic.

Tailored regulation of means by which to effectuate fulfillment of a right (*i.e.*, indirect regulation) is not a violation of the right itself. This Court has upheld a considerable number and variety of regulations designed to foster independent judgment in those who contemplate abortion. *See, e.g., Planned Parenthood v. Casey*, 505 U.S. 833, 873-874 (1992).[34] The states are free to enact

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subgroup, consisting of acute and chronic pain suffered by cancer patients who are dying, include people affected by the decisions in the consolidated cases. These individuals, she notes, require a rapid escalation in analgesic drug therapy and efforts to address each of the various pain symptoms that arise as the varying kinds of pain all come to bear at once.

[34] In *Casey*, the Court elaborated upon the distinction between regulations that have an incidental effect on the exercise of a right and those that "strike at the right itself." The analogy has perfect application to the instant cases. The Court explained:

> As our jurisprudence relating to all liberties save perhaps abortion has recognized, not every law which makes a right more difficult to exercise is, *ipso facto*, an infringement of that right. An example clarifies the point. We have held that not every ballot access limitation amounts to an infringement of the right to vote. Rather, the States are granted substantial flexibility in establishing the framework within which voters choose the candidates for whom they wish to vote [Citations omitted].
>
> The abortion right is similar. Numerous forms of state regulation might have the incidental effect of increasing the cost or decreasing the availability of medical care, whether for abortion or any other medical procedure. The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process Clause.

Casey, 505 U.S. at 874-875.

similar regulations that will foster independent judgment in competent, terminally ill patients who contemplate physician-assisted suicide.

CONCLUSION

For the reasons stated above, the judgments of *Glucksberg* and *Quill* should be affirmed.

Respectfully submitted,

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Nos.95-1858
96-110

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1995

DENNIS VACCO, Attorney General
Petitioner

v

TIMOTHY QUILL, M.D. (and others)
Respondents

STATE OF WASHINGTON
Petitioner

v

HAROLD GLUCKSMAN
Respondent

ON CERTIORARI TO THE SECOND AND NINTH CIRCUIT COURTS OF APPEAL

BRIEF OF AMICUS CURIAE WAYNE COUNTY, MICHIGAN, IN SUPPORT OF THE PETITIONERS

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49 pp

STATEMENT OF THE QUESTION

IS THERE IS A DUE PROCESS RIGHT TO COMMIT SUICIDE, ATTEMPT SUICIDE, OR ASSIST IN A SUICIDE, THOUGH THE CONSTITUTION HAS NOTHING TO SAY ABOUT THE SUBJECT?

TABLE OF CONTENTS

Statement of the Question.....i

Index of Authorities.....iii

Interest of the Amicus.....1

Argument.....2

Framework of Review.....2

The Due Process Question.....8

The Analytical Approach.....8

The Casey Decision.....24

Tradition.....27

Conclusion.....32

Epilogue.....42

Relief.....44

INDEX OF AUTHORITIES

Bowers v Hardwick,
478 US 186 (1986).....20

Cruzan v Missourt,
497 US 261 (1990).....22

Michael H v Gerald D,
491 US 110 (1989).....17

Minnesota v Dickerson,
124 L Ed 2d 334 (1993).....7

Moore v East Cleveland,
431 US 494 (1977).....18

Ogden v Saunders,
12 Wheat 270 (1827).....4

Otis v Parker,
187 US 606 (1902).....9

Palko v Connecticut,
302 US 319 (1937).....14

People v Blodgett,
13 Mich 127 (1865).....6

People v Collins,
3 Mich 343, 349, 405 (1854).....2

People v Gansley,
191 Mich 347 (1917).....2

People v Stambosva,
210 Mich 436, 441 (1920).....4

Planned Parenthood v Casey,
120 L Ed 2d 674 (1992).....24

Blackstone,
Commentaries.....28

Clark and Marshall,
A Treatise on the Law of Crimes.....28

Coke,
Institutes of the Laws of England.....28

Thomas Cooley,
Constitutional Limitations.....2

Ely, John Hart
Democracy and Distrust..... 8

Kamisar,
"Are Laws Against Assisted Suicide
Unconstitutional?" Hastings Center
Report 23 No. 3, p.32 (1993).....29

LaFave and Scott,
Substantive Criminal Law (1986).....30

Marzen, O'Dowd, Crone, and Balch,
"Suicide: A Constitutional Right?"
24 Duquesne L Rev 1 (1985).....31

"Medical Science Under Dictatorship,"
241 New England journal of Medicine 40
(1949).....38

Roth, Philip
The Great American Novel (1973).....9

INTEREST OF THE AMICUS

Amicus is the County of Wayne. The Wayne County Prosecutor's Office has litigated the issue presented in the cases before the Court throughout Michigan courts, both trial and appellate, and the Michigan Supreme Court has found that there is no due process constitutional right to "assisted suicide." Further, Michigan has been the site of over 40 assisted suicides, and the Michigan legislature is awaiting the outcome of the instant cases before determining how to proceed with regard to future legislation in this area. The result in these cases is of great interest and importance to the County of Wayne.

WHETHER "ASSISTED SUICIDE" SHOULD BE PERMITTED IS A QUESTION LEFT BY THE CONSTITUTION TO THE POLITICAL BRANCHES OF GOVERNMENT, AND TO EACH STATE TO DECIDE FOR ITSELF.

I. The Framework of Review

The starting point for all analysis of the constitutionality of a statute is that the constitutionality of the law in question "is to be presumed, because the legislature, which was first required to pass upon the question, acting, as they must be deemed to have acted, with integrity, and with a just desire to keep within the restrictions laid by the constitution upon their action, have adjudged that it is so." Thomas Cooley, Constitutinal Limitations, at 183. See also People v Collins, 3 Mich 343, 349, 405 (1854); People v Gansley, 191 Mich 347 (1917) ("courts in a long series of cases have enunciated the principle that the presumption is in favor of the constitutionality of a statute"). This may

seem a commonplace, but, as Justice Cooley observed elsewhere in his treatise regarding another maxim of construction, while it may "seem so obvious a truism that one expects to see it universally accepted without question" nonetheless it "frequently becomes necessary to re-declare this fundamental maxim." Cooley, at 59.

Because of this presumption of constitutionality, and also because resolution of a challenge to the constitutionality of a statute is "one of the most grave and delicate duties which a judicial tribunal can be called upon to perform," Collins, at 347, Cooley, at 182, Justice Cooley wrote that "when courts are called upon to pronounce the invalidity of an act of legislation...they will approach the question with great caution...and never declare a statute void, unless the nullity and invalidity of the act are placed, in their judgment, beyond a reasonable doubt.

A reasonable doubt must be solved in favor of the legislative action, and the act be sustained.....'It is but a decent respect due to the wisdom, the integrity, and the patriotism of the legislative body by which any law is passed, to presume in favor of its validity, until its violation of the constitution is proved beyond all reasonable doubt.'" Cooley, at 182-183, quoting Ogden v Saunders, 12 Wheat 270 (1827). See People v Stambosva, 210 Mich 436, 441 (1920) (the rule is that "every intendment is to be taken in favor of the propriety and validity of legislative action, and that in case of doubt courts should not interfere to thwart the legislative will").

Of course, it is also a truism that a court may not invalidate a statute because the court believes it "unjust and oppressive," or because "it is supposed to violate the natural, social, or political

rights of the citizen, unless it can be shown that such injustice is prohibited or such rights guaranteed by the constitution." Cooley, at 164. This is so because in exercising the authority to declare a statute unconstitutional judges are not claiming judicial supremacy; rather, "they are only the administrators of the public will. If an act of the legislature is held void, it is not because the judges have any control over the legislative power, but because the act is forbidden by the constitution, and because the will of the people, which is therein declared, is paramount to that of their representatives expressed in any law." Cooley, at 160 (emphasis added).

In examining the constitutionality of a statute, the meaning of the constitutional provision against which the statute is to be measured is obviously of critical

importance. The foremost maxim of construction is that "The object of construction, as applied to a written constitution, is to give effect to the intent of the people in adopting it." Cooley, at 55 (emphasis in the original). This method of construction is a part of our jurisprudential history. The court is to "declare the law as written, leaving it to the people themselves to make such changes as new circumstances may require. The meaning of the constitution is fixed when it is adopted, and it is not different at any subsequent time when a court has occasion to pass upon it." Cooley, at 55. As Justice Campbell put it in People v Blodgett, 13 Mich 127, 138 (1865): "The meaning of our constitution was fixed when it was adopted, and the question which is now before us is not different from what it would have been had the constitution been recently adopted....Constitutions cannot be changed

by events alone. They remain binding as the acts of the people in their sovereign capacity, as the framers of government, until they are amended or abrogated by the action prescribed by the authority which created them." See also Justice Scalia, concurring in Minnesota v Dickerson, 124 L Ed 2d 334, at 348 (1993): it is a "fundamental principle of constitutional adjudication that the terms in the Constitutin must be given the meaning ascribed to them at the time of their ratification." This does not mean that the constitution is "static" in that it cannot be applied to unforeseen events or developments (such as modern technology)--surely, its principles can be applied to new situations, as Justice Campbell recognized over 125 years ago: "That the constitution means nothing now that it did not mean when it was adopted, I regard as true beyond doubt. But it must be

regarded as meant to apply to the present state of things as well as to all other past or future circumstances." Blodgett, at 140 (emphasis added). But the principles do not change--the constitution does not change to meet the times--the constitution is simply capable of application to new circumstances.

II. THE DUE PROCESS QUESTION

> "...there is simply no avoiding the fact that the word which follows "due" is "process"....we apparently need periodic reminding that 'substantive due process' is a contradiction in terms--sort of like 'green pastel redness.'"
>
> John Hart Ely, Democracy and Distrust (Harvard University Press, 1980), p.18.

The Analytical Approach

> "Well, what may seem like the truth to you," said the seventeen-year-old bus driver and part-time philosopher, "may

> not, of course, seem like the truth to the other fella, you know."
>
> "THEN THE OTHER FELLOW IS WRONG, IDIOT!"
>
> Philip Roth, The Great American Novel (1973), p.19.

> "...it by no means is true that every law is void which may seem to the judges who pass upon it excessive, unsuited to its ostensible end, or based upon conceptions of morality with which they disagree....Otherwise a constitution...would be become the partisan of a particular set of ethical or economical opinions, which by no means are held semper ubique et ab omnibus.
>
> Otis v Parker, 187 US 606, 47 L Ed 326 (1902) (Justice Holmes, for the Court)

The attack on the prohibition on assisted suicide generally proceeds by a series of logical progressions, essentially as follows: 1)the Constitution prohibits deprivation by the Government of an individual's life, liberty, or property without Due Process of law; 2)a concept of "personal autonomy" may be located within

the "liberty" protected by the Constitution; 3)that concept of personal autonomy includes a person's ability to control his or her own body--to make "basic decisions regarding bodily integrity"; 4)that ability to control one's own body and make basic decisions regarding bodily integrity includes the liberty to terminate one's life; 4)a prohibition on the liberty interest of self-destruction is therefore unconstitutional (rather than subject to deprivation only upon "Due Process"). It is more than passing strange that under the Due Process Clause one's very life may be taken by the Government, certainly against his or her will, so long as fair procedures are employed, but an alleged aspect of one's right to liberty may not, no matter what the procedure. How can this be? From where does this liberty interest arise that is superior to one's right to live?

One thing is clear: an "undeprivable

even with Due Process" right to liberty/personal autonomy/control of one's body/to commit suicide (and to assist someone in so doing) can be found neither in the text of the Constitution, nor in the history of our Nation, which has never countenanced assisted suicide. It comes, rather, from the belief of those who think it the right, or correct, or moral thing, and must be "constitutionalized" by them to protect it against those to whom it "may not, of course, seem like the truth," because those people, even if they happen to include the democratically elected lawmakers of the society, are simply wrong.

This approach, of course, allowed Chief Justice Taney to declare that there could be no valid law against slaveholding in the United States, slaveholders having a liberty (as well as property) interest in owning slaves with which the Government could not interfere. How did Chief Justice Taney know

this liberty interest existed, it not being stated in the Constitution? He knew it because he was passionately convinced that it must be so. Dred Scott was not decided on the basis of history and tradition giving rise to a liberty interest in slave holding, as history and tradition would not support such a finding, slavery being prohibited in much of the country. It was the prevention of action by the democratically elected legislature--a ursupation of authority by the judiciary--by proclaiming that the legislature was without power to ban slavery in the territories through the finding of a liberty interest in the slave holder which helped precipitate the Civil War. Dred Scott was decided on the Respondents' defendant's theory of constitutional adjudication; that is, that the Constitution is an empty vessel into which the judiciary may pour whatever meaning it chooses, the object of the parties to constitutional

disputes being to convince the court as to which side has the better moral philosophy.

Respondents can offer no principle by which statutes prohibiting assisted suicide may be overturned which would in any way serve as a check on the personal predilections of the judiciary. In short, the approach of the Respondents and the courts below is simply moral philosophy, attempting to engraft a particular moral philosophy into the Constitution, and as Professor Ely has said, "our society does not, rightly does not, accept the notion of a discoverable and objectively valid set of moral principles, at least not a set that could plausibly serve to overturn the decisions of our elected representatives." Because history and tradition demonstrate that there is no constitutional right to assisted suicide does not disable the legislature from deciding to allow the practice. It is a finding of

unconstitutionality which freezes tradition and history, which ends debate on the matter, not a finding of constitutionality, which allows the democratic process to continue to work.

The Constitution not properly being a flag to be captured by whomever can persuade a majority of Justices as to their view of moral philosophy, thereby completely shutting out competing views, what approach is to be taken as a matter of law and not philosophy to identification of liberty interests? Palko v Connecticut, 302 US 319, 82 L Ed 288 (1937) demonstrates the method.

Today, the doctrine of "selective incorporation" of the Bill of Rights has captured the field as to most of the rights protected by the Bill of Rights, so that it is held that the "Due Process" required by the 14th Amendment of the States includes most of the Bill of Rights. But before selective incorporation there was Palko, and

the approach of Palko is still valid with regard to claims of liberty interests or procedural protections not contained within the Bill of Rights. In that case the defendant was found guilty of murder in the second degree after a trial for first degree murder, and the state appealed, as was allowed under Connecticut law. On appeal it was found that error had been committed in excluding the defendant's confession, in excluding testimony to impeach his credibility, and in instructing the jury on the difference between first and second degree murder. Palko was retried, convicted of first degree murder, and sentenced to death. He claimed that jeopardy precluded the retrial which he had not sought.

Because the Bill of Rights, and therefore the jeopardy provision, was not (then) applicable to the States, the Court looked to the Due Process Clause of the 14th Amendment to see if the practice of

Government appeal and retrial offended that clause. The Court stated that those protections which may be found to be "implicit in the concept of ordered liberty" are applicable to the States through Due Process requirements. A liberty interest or procedural protection exists if "so rooted in the traditions and conscience of our people as to be ranked fundamental." In the case before it the Court concluded that because the state was not "attempting to wear the accused out by a multitude of cases with accumulated trials," but instead asking only that "the case against him shall go on until there shall be a trial free from the corrosion of substantial legal error," this was not "cruelty at all"; indeed, to allow the state an appeal with regard to trial error was, said the court, "no seismic innovation. The edifice of justice stands, in its symmetry, to many, greater than

before." 82 L Ed at 293-294.

As stated, the total incorporation/selective incorporation/no incorporation struggle with regard to the Bill of Rights has ended with the victory of selective incorporation, but for claims outside the Bill of Rights the Palko approach remains viable. Michael H. v Gerald D., 491 US 110, 105 L Ed 2d 91, 109 S Ct 2333 (1989) illustrates the point. The petitioner maintained an adulterous relationship with a married woman who was cohabiting with her husband, and a child was born, which was almost certainly his. The mother reconciled to her husband, and state law conclusively presumed that the issue of a wife cohabiting with her husband, who was not impotent or sterile, was the child of the marriage. The purpose of the statute was to protect the privacy and integrity of the family; the petitioner, however, wished to establish visitation rights with the

child, which he could only do by establishing paternity, which the law precluded. He claimed that the state statute was unconstitutional because he had a liberty interest in his relationship with his child.

The Court rejected the claim. The plurality opinion observed that the Court itself had previously expressed concern regarding the recognition of "new" liberty interests under Due Process claims, "lest the only limits to...judicial intervention become the predilections of those who happen at the time to be Members of this Court." Moore v East Cleveland, 431 US 494, 52 L Ed 2d 531, 97 S Ct 1932 (1977). As Justice White observed in dissent in Moore, "the present construction of the Due Process clause represents a major judicial gloss on its terms, as well as on the anticipation of the Framers..., the Court should be extremely reluctant to breathe still further

substantive content into the Due Process Clause so as to strike down legislation adopted by a State or city to promote its welfare. Whenever the Judiciary does so, it unavoidably pre-empts for itself another part of the governance of the country without express constitutional authority."

The approach cannot be one of personal predilection then, said the Court, so that "we have insisted not merely that the interest denominated as a 'liberty' be 'fundamental'...but also that it be an interest traditionally protected by our society," that it be "rooted in history and tradition." (emphasis supplied, 105 L Ed 2d at 105). Finding that the relation between persons in the situation of the petitioner and his child had not been protected under our historic practices (indeed, the historic tradition is the other way, to protect the integrity and privacy of the family), the Court rejected the claimed liberty interest.

See also Bowers v Hardwick, 478 US 186, 92 L Ed 2d 140, 106 S Ct 2841 (1986).

Moore v East Cleveland, cited above, itself also demonstrates the appropriate method. A housing ordinance limited occupancy of dwellings to members of a single family, and defined "family" as essentially only the "nuclear" family. A woman was convicted of violating the ordinance because she lived with her son and two grandsons, and the grandsons were not brothers but cousins. In dissent from the finding of unconstitutionality of the ordinance, Justice White expressed the concerns above noted regarding judicial usurpation of legislative authority under the auspices of the Due Process Clause, based on nothing other than the predilections of the Justices. Justice Powell, the author of the lead opinion, also appreciated this concern, agreeing that "there are risks when the judicial branch

gives enhanced protection to certain substantive liberties without the guidance of the more specific provisions of the Bill of Rights....there is reason for concern lest the only limits to such judicial intervention become the predilections of those who happen at the time to be Members of this Court....history counsels caution and restraint." How, then, to avoid decisions based only on a particular moral philosophy embraced by a majority of Justices? Justice Powell supplied the answer: "Appropriate limits on substantive due process come...from careful 'respect for the teachings of history (and) solid respect for the basic values that underlie our society.'" 52 L Ed 2d at 540. Addressing Justice White's dissent directly, Justice Powell stated that defining the substantive content of liberty interests to be found in the Due Process Clause by looking to "history and tradition" imposes "meaningful

limits" on the judiciary. 52 L Ed 2d at 540, fn 12 (emphasis added). While reasonable people may at times disagree as to what history and tradition demonstrate, at least they are engaged in the same enterprise, and where history and tradition point in a certain direction, judges are not free to disregard it in favor of their own views of moral philosophy or ethical values.

Cruzan v Director, Missouri Department of Health,, 497 US 261, 111 L Ed 2d 224, 110 S Ct 2841 (1990) in no way supports the circuit courts' usurpations of legislative authority; indeed, read properly, it virtually compels the opposite conclusion. The claimed liberty interest there was a right to refuse life-sustaining medical intervention, and more precisely, whether the decision of the State that it must be demonstrated by convincing evidence that the individual who is being treated would desire the cessation of treatment was

constitutional. The Court looked again to history and tradition. It is in our tradition that the touching of another person, including through medical treatment, without permission, or "informed consent," is a battery, which can lead to damages. As the Court observed, the "logical corollary of the doctrine of informed consent is that the patient generally possesses the right not to consent, that is, to refuse treatment." 111 L Ed 2d at 236. The Court specifically declined to view the matter as involving a generalized constitutional right of privacy, analyzing the question instead in terms of a liberty interest to avoid unwanted touching or intervention upon one's body, and looking to history and tradition. The Court concluded in the end that this liberty interest can be regulated by the State with process that is "due," and held that requiring a showing of convincing evidence was not improper, or "undue." On

its way to this conclusion the Court discussed the State's interest in the matter, noting in support of the State's interest that "the majority of States in this country have laws imposing criminal penalties on one who assists another to commit suicide." 111 L Ed 2d at 243. How possibly could the Court have looked to the fact that the majority of states have laws imposing criminal penalties for assisted suicide as a factor in favor of the State's interest on the issue of terminating medical care if those state laws are in fact unconstitutional? Cruzan provides no support for the circuit court decisions, but mandates the conclusion that theyerred egregiously.

The Casey Decision

Respondets, as well as the circuit court decisions, rely heavily on the triune joint opinion in Planned Parenthood v Casey, 120 L Ed 2d 674 (1992). The decision,

however, plays them false. Casey, albeit in a way previously unknown in jurisprudence, "retained" the "essential holding of Roe v Wade...." (retained in a way previously unknown in jurisprudence in that the joint opinion also modified the "essential" holding of Roe v Wade, see Justice Scalia, dissenting, at 120 L Ed 2d at 791: "I confess never to have heard of this new, keep-what-you-want-and-throw-away-the-rest version" of stare decisis). The opinion threw out the trimester approach of Roe in favor of a viability approach; that is, it held that the State may absolutely prohibit abortions, save when necessary to save the life or health of the mother, after fetal viability. Thus, once the fetus has attained the degree of development that the Court is willing to recognize as "life," the interest of the State in protecting life outweighs the interest of personal autonomy, so that the State may prevent the abortion.

See 120 L Ed 2d at 710. Even before viability, the State's "profound interest" in what the opinion called "potential life" allows regulation, so long as an undue burden is not placed on the decision to obtain an abortion, an "undue burden" being a provision of law the purpose of effect of which is to place a "substantial obstacle" in the path of a woman seeking an abortion "before the fetus attains viability." 120 L Ed 2d at 715. At viability, however, the State's interest overtakes the individual liberty interest created in Roe, and nontherapeutic abortions may be prohibited.

This does not advance the respondents' cause, for even abortion law, then, recognizes an overwhelming State interest in protecting life that has reached that form which the Court is willing to recognize, which, in the case of a fetus, is viability, that state of development where the fetus could survive outside the womb. If the

State's "profound interest" in protecting life overtakes the right of liberty created in Roe, how can it possibly be said that it ends at some point after birth? The interest of the State is surely at least as profound after birth as at viability, as history teaches. The only possible answer of the respondents is that life may reach a point where it should not be considered life--it should be defined "out of" life--for it has become "not worth living." But this question of moral philosophy is one to be debated before legislatures, not one for the imposition of a particular answer by judges, and history teaches that the concept of a life not worthy to be lived is a dangerous notion indeed. Casey supplies no succor to respondents.

Tradition and Assisted Suicide

Do, then, our traditions and our history recognize a right to suicide, and to assist another in its commission (leaving

aside whatever the history and traditions of other nations, such as Greece and Rome, reveal)? Clearly not, as the Court of Appeals recognized. In England, suicide was a form of common law murder, described as either self-murder, see 3 Coke, Institutes Of The Laws of England 54 (1797), 4 Blackstone, Commentaries 189, or the decedent being deemed "the murderer of himself." . W Clark and W Marshall, A Treatise On The Law of Crimes, sec. 10.03, at 623 (7th Ed, 1967). It was punishable by burial in the highway with a stake through the suicide's body and forfeiture of all his goods to the crown. According to Blackstone, common law felonious homicide occurred "when a person of sound memory and discretion, unlawfully killeth any reasonable creature in being, and under the king's peace, with malice aforethought, either express or implied." Blackstone specifically stated that murder may be

"either by killing one's self, or another man." 4 Blackstone, Commentaries, 188, 195.

Suicide is no longer considered criminal, but not because the act does not fall within the definition of murder, but because no punishment is provided for self-murder. Forfeiture of all property and burial in the highway with a stake through the suicide's body is no longer considered appropriate. This change was accomplished not to legitimize the act of suicide, but to spare the family of the suicide. See e.g. Kamisar, "Are Laws Against Assisted Suicide Unconstitutional," Hastings Center Report 23, no. 3, p.32 (1993). However, aiding a suicide still falls within the common law definition of murder, and, where there is no other specific offense for the crime of assisted suicide, is therefore punishable according to the ordinary statutory penalties. The position taken by some that because neither suicide nor attempted

suicide are criminalized that it is therefore "logically incomprehensible" to charge a person with aiding and abetting a "lawful act," is wholly unpersuasive; indeed, Professor LaFave has derided the view that because suicide is no longer punished assisted suicide is also not criminal as "most certainly unsound." 2 LaFave and Scott, Substantive Criminal Law, sec. 7.8(c), at 249 (1986). The most celebrated model code with regard to criminal law, the Model Penal Code, not only prohibits assisted suicide in sec. 210.5, but grants a privilege to those who use force to prevent a suicide. See sec. 3.07(5). The Code was drafted after years of study, by the most eminent criminal law scholars, and itself is proof that there has not existed a historically recognized right to commit suicide or to assist in a suicide. See Kamisar, at 33.

Moreover, at the time of the ratification of 14th Amendment 21 of the 37 existing states, and 18 of the 30 ratifying states, prohibited assisted suicide. And even those states which had not spoken to the issue in 1868 held that assisted suicide was unlawful when the issue was faced. See Marzen, O'Dowd, Crone, and Balch, "Suicide: A Constitutional Right?," 24 Duquesne L Rev 1, 76-100, 148-242 (1985). It can readily be said that there is no significant support whatever for any claim that a right to suicide, or to assist in suicide, is "so rooted in our tradition that it may be deemed fundamental or implicit in the concept of ordered liberty."

There is not in this country, then, a tradition protecting suicide or assisted suicide. The question is one for the political branches of government.

Conclusion

> "It is precisely historical practices that define what is 'due.' 'Fundamental fairness' analysis may appropriately be applied to departures from traditional American conceptions of due process; but when judges test their individual notions of 'fairness' against an American tradition that is deep and broad and continuing, it is not the tradition that is on trial, but the judges."
>
> Justice Scalia, concurring in Schad v Arizona, 115 L Ed 2d 555 (1991)

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* See Alexander Bickel, The Supreme Court and The Idea Of Progress (Yale University Press: 1978), p. 84: "The independence of the judges is an absolute requirement if individual justice is to be done....But supreme judicial autonomy, the judge answerable only to his own conscience in making policy for the society, in adjusting, conformably to one or another choice of values, the conflicting interests, desires, and ethical and moral aspirations and preferences of the groups that constitute the society--that is something else again...."

The claim that assisted suicide is protected by the Due Process Clause fails as a matter of history and tradition, and fails in its attempt to broadly state the right as a right of "personal autonomy," which does not exist. There are particular rights of personal autonomy, such as the right not to be seized under the Fourth Amendment absent probable cause or reasonable suspicion, but a general right to personal autonomy is a right to be free of all law. The line-drawing the decisions of the circuit courts would require is classic judicial legislation. If there is a right to personal autonomy which includes a right to self-destruction, how can it possibly be limited? Why would not a person simply tired of life have a right to "blow his brains out" or drown him or herself without interference by the state? And if there is a right of personal autonomy, which includes

the right to control one's own body and make basic decisions regarding bodily integrity, why does it not include a right of consenting adults to engage in acts of incest? Why does it not include the right of a competent minor to engage in sex with an adult (how can statutory rape exist as a crime where the act is consensual?). Why does it not include the right to polygamous marriages? Why does it not include the right to take psychotropic drugs for recreational purposes? Why can an individual who causes harm to him or herself be committed to an institution as a threat to him or herself?

The "right" which has been invented by the circuit courts here is rife with line-drawing impossibilities. Could it possibly be plainer that if a right of "personal autonomy" as recognized by the circuit court exists then then a right to suicide must include all of "us"--it cannot

be said that it does not extend to those that are suffering physical pain but are not terminally ill, that it does not extend to those that are suffering "psychic" pain but are not physically ill at all, that it does not extend to anyone for any reason whatsoever. Further, any attempt at linedrawing necessarily involves the government in determining whether a life is "worthy to be lived." If the right is invented and limited to the terminally ill, when does it come into being? We are terminal from the moment of conception; when a specific illness has overtaken us, so that our death is reasonably predictable, does the "right" exist 3 months from death, 6 months from death, one year from death, five years from death? Does it not exist for those who are terminally ill, but who are not suffering great pain, and who determines whether pain is being suffered, and its degree? If the "right" belongs only to the

terminally ill who are suffering, by whatever standard, how can it be denied to those who are suffering "psychic" pain? How can a court possibly arrogate to itself the right to tell these people that though "The power to determine the limits to which one can endure pain and agony is certainly intrinsic to this basic concept of personal autonomy," it does not belong to <u>them</u>, so that rather than being treated (as many are, to full recovery) they should simply be assisted in achieving their deaths. As Professor Kamisar has observed, "if a competent person comes to the unhappy conclusion that his existence is unbearable and freely, clearly, and repeatedly requests assisted suicide, why should he be rebuffed because he does not 'qualify' under somebody else's standards? Isn't <u>this</u> an arbitrary limitation of self-determination and personal autonomy? 'How,' asks Daniel Callahan, 'can self-determination have any

limits? Why are not the person's desires or motives, whatever they be, sufficient?'" Kamisar, at 37. The People have simply not spoken on this question through the Constitution, and thus it is for the legislature.

Moreover the concern, expressed by Professor Kamisar, that "In a climate in which suicide is the 'rational' thing to do, or at least a 'reasonable' option," that it will "become the unreasonable thing <u>not</u> to do? The noble thing <u>to</u> do?....how likely is it that an old or ill person will be encouraged to spare both herself and her family the agony of a slow decline, even though she would not have considered suicide on her own?" is certainly legitimate. In this vein, amicus would point out that time and again the enactment and application of prohibitions on assisted suicide has been compared by one practitioner of this assistance to "Germany in the 1930's and

1940's," it being said that officials there and then also said they were "just following the law." This is bad logic, bad law, and bad history. Atrocities occurred in Germany not because people "followed the law," but because the law broke down; the nation of Germany was ruled by the cult of personality, by one who thought his notions of moral philosophy superior to all others, and who had the military power to put his philosophy into action. Those who committed atrocities in his name did not "follow the law," they followed orders. It was the suppression of democracy in favor of a "power elite" which was, in its view, above the law, which led to the Holocaust.

An article published in 1949 is also instructive in this regard. The article is "Medical Science Under Dictatorship," 241 New England Journal of Medicine 40 (1949). The article examines the question of how respected men of science--physicians--could

have engaged in atrocities under Nazi rule. The article, being published in 1949, has nothing to do with assisted suicide, not being written by a "partisan" of one side or the other of this question of moral philosophy and policy, but being concerned with physician atrocities during the War. The author concluded:

> Whatever proportions these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitude of the physicians. It started with the acceptance of the attitude, basic in the euthenasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages concerned itself merely with the severely and chronically sick. Gradually the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which this entire trend of mind received its impetus was

> the attitude toward the nonrehabilitable sick.

241 N Eng Jrnl of Med at 44 (emphasis added).

As stated earlier, Justice Cooley long ago correctly observed that in exercising the authority to declare a statute unconstitutional judges are "only the administrators of the public will. If an act of the legislature is held void, it is not because judges have any control over the legislative power, but because the act is forbidden by the constitution, and because the will of the people, which is therein declared, is paramount to that of their representatives expressed in any law." Cooley, at 160 (emphasis added). History clearly teaches us that the people have not expressed their will in the constitution that assisted suicide be protected, and there is thus nothing in the constitution which is paramount to the decision of the people's elected representatives, in our

constitutional democracy, to continue to prohibit it.

The "right" sought to be pounded into the Constitution by the lower courts simply cannot be found there, but is one which must be sought in the political arena, there being no principled basis upon which to locate it in the Due Process Clause. It can only be found there when judges assert their personal and individual predilections as being law. To conclude by reiterating Professor Ely: "...reasoning about ethical issues is not the same as discovering absolute ethical truth...our society does not, rightly does not, accept the notion of a discoverable and objectively valid set of moral principles, at least not a set that could plausibly serve to overturn the decisions of our elected representatives." This court should reverse the circuit courts.

Epilogue

"...(suppose) a statute making it a crime for any person to remove another person's gall bladder, except to save that person's life. Surely....that has to be unconstitutional...."

"I don't think that law is unconstitutional....If it passed, I think we could get it repealed pretty quick."

"What if we couldn't?"

"Then I'd suppose my elected representatives had found something about gall bladders that you and I are unaware of."

"Suppose they hadn't. Suppose they were just acting crazy."

"Vote them out. Impeach them. Repeal the law."

"Can't. Most people believe they're doing the right thing."

"And they're just acting crazy too?"

"Right."

"I don't suppose we can reason with them?"

"Nope."

"You know what you're telling me? That you don't believe in democracy."

Ely, at 182 (emphasis added).

RELIEF

Wherefore, amicus respectfully submits that the circuit courts should be reversed.

Respectfully submitted,

JOHN D. O'HAIR
Prosecuting Attorney
County of Wayne

TIMOTHY A. BAUGHMAN
Chief of Research,
Training and Appeals

MOTION FILED

DEC 9 1996

(63)

Nos.95-1858
96-110 (64)

IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1995

DENNIS VACCO, Attorney General
Petitioner

v

TIMOTHY QUILL, M.D. (and others)
Respondents

STATE OF WASHINGTON
Petitioner

v

HAROLD GLUCKSBERG
Respondent

ON CERTIORARI TO THE SECOND AND NINTH CIRCUIT COURTS OF APPEAL

MOTION TO FILE BRIEF AS AMICUS CURIAE ON BEHALF OF WAYNE COUNTY, MICHIGAN, IN SUPPORT OF THE PETITIONERS, OUT OF TIME

JOHN D. O'HAIR
Prosecuting Attorney
County of Wayne

*TIMOTHY A. BAUGHMAN
Chief of Appeals
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*counsel of record

4 pp

MOTION TO FILE AS AMICUS CURIAE OUT OF TIME

NOW COMES Wayne County, Michigan, by John D. O'Hair, the Prosecuting Attorney of the County of Wayne, and Timothy A. Baughman, Chief of Research, Training and Appeals, and requests permission to file as amicus curiae in support of the petitioners out of time, as as reasons says as follows:

1. Amicus Wayne County has stated the reasons for filing as amicus in the brief itself.

2. The brief has itself been filed, and no delay will be occasioned in its consideration or review by the Court.

3. The brief was filed two days after the time for filing by the Petitioners, and an

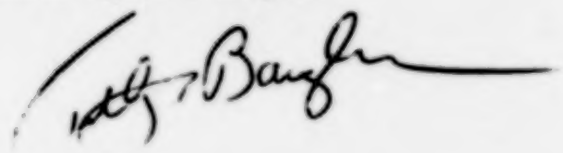
amicus must file within the time for filing of the party supported. Regrettably, counsel for amicus was unaware of the expedited schedule for filing set for the parties, and apologizes for the delay in filing.

RELIEF

Wherefore, amicus respectfully requests that the motion to file as amicus out of time be granted.

Respectfully submitted,

JOHN D. O'HAIR
Prosecuting Attorney
County of Wayne



TIMOTHY A. BAUGHMAN
Chief of Research,
Training and Appeals